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How Are State Insurance Marketplaces Shaping Health Plan Design?

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Abstract: Part of states' roles in administering the new health insurance marketplaces is to certify the health plans available for purchase. This analysis focuses on how state-based and state partnership marketplaces are using their flexibility in setting certification standards to shape plan design in the individual market. It focuses on three aspects of certification: provider networks; inclusion of essential community providers; and benefit substitution, which allows plans to offer benefits that differ from a state's benchmark plan. A review of documents collected from 18 states and the District of Columbia finds that 13 states go beyond the minimum federal requirements with respect to provider network standards, four states specify additional standards for including essential community providers, and five states and Washington, D.C., bar benefit substitution. These interstate variations in plan design reflect the challenges policymakers face in balancing health care affordability, benefit coverage, and access to care through the marketplace plans.

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OVERVIEW

On October 1, 2013, the health insurance marketplaces[1] established under the Affordable Care Act (ACA) began accepting enrollment by individuals and families into qualified health plans offered by private insurers. Coverage begins in January 2014 for people who enroll by December 23, 2013, and the initial open enrollment period ends on March 31, 2014. Certification of the plans being sold depends on several factors, including that plans are offered by licensed insurance issuers and meet minimum federal standards. However, federal regulations give states some flexibility over the certification standards.[2]

States also have flexibility in choosing how its marketplace will operate. A state may establish and operate its own state-based marketplace or choose a "federally facilitated marketplace" operated by the federal government.[3] States may also elect to enter into a formal "state partnership marketplace," with the partnership with the federal government focusing on issues related to consumer assistance and/or plan management.[4] Exhibit 1 shows that as of June 2013, 16 states and the District of Columbia had opted for a state-based approach to the individual marketplace, while seven had elected to partner with the federal government.

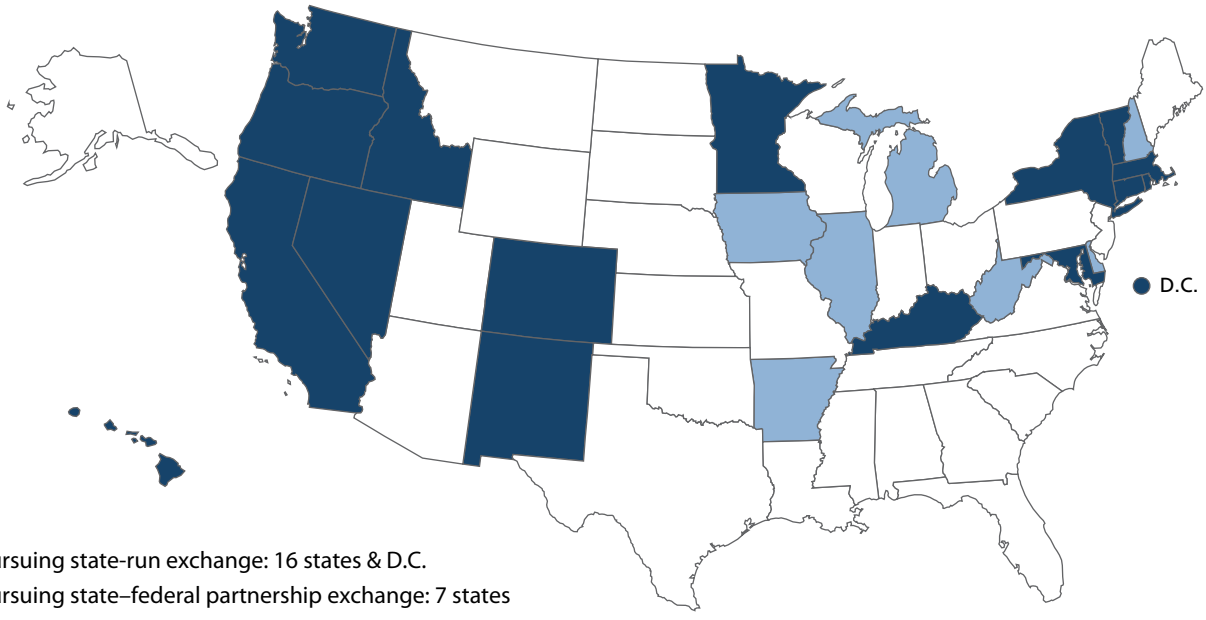
Marketplaces in the remaining states are being run by the federal government.

As described above, certification as a qualified health plan depends on two key factors. First, the plan issuer (the insurer) must be licensed and in good standing in the state. Second, the plan must meet minimum federal certifications standards.[5] For example, the plan must provide information about benefits and rates, cover "essential health benefits" in a non-discriminatory fashion, and meet certain transparency requirements and minimum provider network adequacy standards.[6] One of the requirements for provider networks is that a plan must include certain "essential community providers."[7] States operating their own marketplaces have the option to exclude plans that meet the certification requirements if they determine such exclusion to be in the best interest of individual and group buyers.[8]

Under federal law, states also have the power to set higher standards for health plans to qualify to sell in the exchange, as long as their standards do not "prevent the application" of (i.e., work against) federal standards.[9] Federal regulations specify three areas in which states may adopt additional standards. First, states can decide whether they will permit plans to substitute one group of covered treatments for another (known as benefit substitution)—for example, offering less habilitative coverage and more rehabilitative coverage.[10] (Benefit substitution is not permitted in the case of prescribed drugs). Second, states can set more detailed provider network standards.[11] Third, states can set standards for the inclusion of certain "essential community providers" that treat medically underserved and vulnerable populations.[12] Examples of such providers include community health centers, family planning clinics, and clinics that receive Ryan White Care Act funding to furnish treatment to patients with HIV/AIDS. A more extensive list of essential community providers was issued by the federal government in April 2013.[13]

Because the marketplaces are new, there is limited evidence on how any particular certification standard ultimately may affect consumers' access to

Exhibit 1. What States Are Doing to Establish an Insurance Marketplace as of December 2013



Note: The U.S. Department of Health and Human Services denied Mississippi's application for a state-run marketplace on February 7, 2013.
Utah plans to operate its small-business marketplace. The federal government will operate the state's individual marketplace.
In New Mexico, the federal government will operate the individual market in 2014.
Sources: National Conference of State Legislatures, Federal Health Reform: State Legislative Tracking Database, www.ncsl.org/default.aspx?TabId=22122; Politico.com; Commonwealth Fund analysis.

care, the quality of care, or health outcomes. For their part, health insurers tend to view stricter regulation as adding to the price of plans. Therefore, in deciding whether and how to use their health plan certification flexibility, states must balance concerns about the possible effects of standards on access to care and care quality on the one hand, and costs on the other.

To learn how state-based and state partnership marketplaces are exercising their flexibility to shape plan design, we reviewed documents collected from 18 states and the District of Columbia (see p. 5 for more on our study methods). Our investigation focuses on three attributes of health plans: 1) provider networks; 2) the inclusion of essential community providers; and 3) benefit substitution.

FINDINGS

Provider Networks

Federal standard. Federal rules require that a plan's provider network be "sufficient in number and types of providers, including providers that specialized in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay."[14] The term "unreasonable delay" is not defined; without further definition, it would be up to a plan to define the term, and there could be considerable variation among plans in how reasonableness (in terms of travel time or wait time) is determined on matters such as routine care, appointments for preventive care, or appointments with specialists. While health plan industry accreditation standards (which differ from the federal certification process) do address network access and adequacy, these accreditation requirements are being phased in.[15]

How states use their flexibility. Thirteen of 18 states, as well as the District of Columbia, specify additional standards to supplement the federal rule on provider networks. Appendix Table 1 presents examples of the most common criteria included in state approaches to defining a sufficient provider network. For example, 12 states have created some additional standards related to maximum travel time. Delaware specifies both geographic distances and drive time for access to primary care services, as does Vermont. Colorado does not specify time and distance requirements, but instead requires plans to demonstrate network sufficiency based on "reasonable criteria established by the issuer." Colorado also offers examples of "reasonable criteria," which include distance to provider, access to specialty care through telemedicine, and cross-county geographic accessibility.[16] California specifies that services must be reasonably accessible by public transportation in order to ensure access to care in urban environments and requires plans to offer the same provider network across all coverage tiers. Using the federal standards are Arkansas, Connecticut, Maryland, Michigan, Oregon, and the District of Columbia.[17]

Essential Community Providers

Federal standard. Under the ACA, essential community providers (ECPs) include a range of entities that are eligible to participate in a special federal prescription drug discount program (Section 340B) for medically underserved and vulnerable populations. Federal rules specify that qualified health plans "must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the qualified health plan's service area, in accordance with the Exchange's network adequacy standards."[18] The term "broad range" is not defined. Federal guidance establishes a safe harbor standard used in the case of plans operated in the federal marketplace: inclusion of 20 percent of all essential community providers in the plan's service area, plus all Indian providers in the service area, plus at least one ECP per provider category.[19] At the same time, the guidance gives plans much discretion over ECP inclusion, since plans can disregard the safe harbor and use an alternative standard with an explanation of how they will ensure access.

How states use their flexibility. Four states go beyond the federal standards and apply inclusion criteria for

essential community providers (Appendix Table 2). California, for example, requires plans to have contracts with at least 15 percent of Section 340B providers in a plan service area, with geographic distribution. But the state also eliminates "single service" providers from this requirement (e.g., family planning clinics).[20] By contrast, Colorado uses a more expansive definition of entities considered ECPs, moving beyond Section 340B participation to include providers that have a "demonstrated commitment" to serving the poor and utilize a sliding fee scale. Connecticut offers the most detailed approach: plans ultimately must include 75 percent of all ECPs and are specifically directed to contract with community health centers. Following the federal minimum are Arkansas, Delaware, Illinois, Iowa, Maryland, Michigan, Nevada, New Hampshire, New Mexico, New York, Oregon, Vermont, Washington, West Virginia, and Washington, D.C.

Benefit Substitution

Federal standard. Federal rules allow issuers to substitute benefits that are "actuarially equivalent" to the state benchmark benefits being replaced. Federal rules permit benefit substitution only for benefits that are in the same benefit class. For example, preventive and wellness services and chronic disease management are in the same essential health benefit class, as are mental health and substance abuse disorder services. Under benefit substitution, a plan might increase mental health coverage while reducing substance abuse coverage. Federal rules allow states to adopt stricter substitution standards or to prohibit it completely.[21]

How states use their flexibility. Nine states use the federal standard (Arkansas, Colorado, Delaware, Iowa, Minnesota, New Hampshire, New Mexico, Nevada, and Oregon), either repeating it verbatim or defaulting to it through silence, as Minnesota does (Appendix Table 3). California, Connecticut, Maryland, Michigan, Washington, and the District of Columbia bar substitution entirely. Another four states (Illinois, New York, Vermont, and West Virginia) permit substitution but in ways that vary from the federal regulations. Vermont's standard essentially parallels the federal rule, while New York specifies the types of substitutions that are permissible. New York also, in its "nonstandard plan" categories, permits substitutions that augment certain benefit classes.[22] West Virginia, while allowing benefit substitution, requires parity between habilitative and rehabilitative benefits.

DISCUSSION

This analysis shows how states that operate their own marketplaces or formally partner with the federal government to run them are starting to use their flexibility over health plan design. States vary in the extent to which they elect to apply federal standards or augment them. Among those examined here (18 states plus Washington, D.C.), states are most likely to add requirements to the provider networks standard and significantly less likely to add inclusion criteria for essential community providers. States vary greatly in their approach to benefit substitution, with few states barring substitution outright.

This variation reflects the degree to which states have used their flexibility to shape initial plan design, particularly in the early years when experience with the health insurance marketplaces is limited. It provides evidence that states are seeking to balance health plan affordability against the quality and comprehensiveness of coverage. Our discussions with state marketplace staff confirmed this. Staff noted that they faced several challenges in getting their marketplaces off the ground, including the complexities of interacting with their state insurance departments, delays in issuing federal rules, and the lack of experience with the new market for subsidized health plans. Staff noted that these challenges may hinder their ability to enact more extensive standards for benefit and coverage design, at least initially. The regulatory choices that states make may change, of course, as they gain greater experience with the marketplaces. Marketplace staff were extremely interested in hearing how other states developed certification standards, particularly those aimed at ensuring good-quality coverage and reasonable access to care.

These early efforts at the formulation of qualified health plan standards suggest that standard-setting in the marketplace will undergo an evolution over time. Tracking this evolution will be essential to measure its effects on health care access and quality over time.

About the Study

Our prior research for The Commonwealth Fund showed that states that enacted legislation to establish their own marketplaces structured their laws to give them flexibility on matters such as qualified health plan design and operational oversight.[a] Building on our earlier work, we undertook this "downstream" analysis of state certification policies for health plans participating in the exchanges. We also included state partnership marketplaces, given the flexibility that states participating in these partnerships have to shape certification standards. We focused on the three areas in which state flexibility is given special emphasis under federal rules: provider networks, inclusion of essential community providers, and benefit substitution.

In conducting this analysis, we reviewed numerous documents related to the health plan certification process: state statutes and regulations, requests for proposals, governing board–issued policies, and other policy documents. As of early June 2013, when this phase of our analysis was completed, a total of 18 states and the District of Columbia had developed written specifications for qualified health plans sold to individuals and families through the marketplaces. This included 12 state-based marketplaces (California, Colorado, Connecticut, Maryland, Minnesota, Nevada, New Mexico, New York, Oregon, Vermont, Washington, and the District of Columbia) and seven federally facilitated marketplaces (Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, and West Virginia).

Our reviews were designed to gather information on how and to what extent each state included in the analysis uses its flexibility in addressing issues related to provider networks, essential community provider inclusion, and benefit substitution. In addition, we interviewed marketplace staff in seven states to gain further insight into their decisions regarding whether and how to expand or alter the federal minimum standards.

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[a] S. Rosenbaum, N. Lopez, T. Burke et al., *State Health Insurance Exchange Laws: The First Generation* (New York: The Commonwealth Fund, July 2012).

Notes

1 The name given by the Obama Administration to the Health Insurance Exchanges created by the Act.

2 42 U.S.C. §§ 18031, 18041, added by the Patient Protection and Affordable Care Act §§ 1311, 1321.

3 42 U.S.C. § 18041(b), added by PPACA § 1321(b).

4 42 U.S.C. § 18041(c), added by PPACA § 1321(c).

5 45 CFR Subpart C of Part 156.

6 42 U.S.C. § 18031(c)(1)(B); 45 C.F.R. § 156.230.

7 42 U.S.C. § 18031(c)(1)(C); 45 C.F.R. § 156.235.

8 45 CFR §155.1000(c).

9 Public Health Service Act §2724(a).

10 Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value and Accreditation Final Rule. 78 Fed. Reg. 37 (Feb. 25, 2013), pp. 12834–72, 12844, http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf; 45 C.F.R. § 156.115(b).

11 45 C.F.R. § 156.230.

12 45 C.F.R. § 156.235.

13 CMS/CCIIO, Letter to Issuers on Federally Facilitated and State Partnership Exchanges (April 5, 2013), http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

14 45 C.F.R. §156.230(a)(2).

15 45 C.F.R. §156.275(c)(2)(iv).

16 Colorado Revised Statutes §10-16-704.

17 Arkansas and Maryland are using the federal minimum for 2014 and will revisit the need for additional standards for plan year 2015.

18 45 C.F.R. §156.235.

19 Health insurance companies in state partnership marketplaces (and federally facilitated marketplaces) can meet the federal essential community provider (ECP) standard by either: 1) showing that at least 20 percent of available ECPs in the service area participate in the plan's network; or 2) demonstrating that at least 10 percent of the ECPs available in the service area participate in the plan's network. CMS, *Letter to Issuers on Federally-facilitated and State Partnership Exchanges*, April 5, 2013.

20 California Health Benefit Exchange, *Explanation of Updated 340B Provider List,* Jan. 29, 2013.

21 45 C.F.R. § 156.115(b).

22 Nonstandard products are permitted to: 1) modify cost-sharing in any category; 2) add benefits to an essential health benefit category (i.e., higher visit limitations); and 3) add benefits that are not considered essential health benefits.

Appendix Table 1. Thirteen States Have Provider Network Adequacy Standards Exceeding the Federal Minimum

State	No Additional Standards	Maximum Travel Time	Provider/ Enrollee Ratio	Maximum Appointment Wait Time	Hours of Operation	Specialist Standards	Specifies Provider Type to Be Included in Network
AR*†	X						
CA				X			X
CO		X	X	X	X		
CT	X						
DE †		X	X				
DC	X						
IL †		X	X	X	X	X	
IA †		X	X	X	X		
MD*	X						
MI	X						
MN		X	X	X	X		
NV		X	X				X
NH †		X	X	X	X		X
NM †		X	X	X	X		
NY		X	X				X
OR	X						
VT		X		X	X		
WA		X		X	X		X
WV †		X	X				

* 2014 only—states will reassess whether federal standards are adequate for plan year 2015.
† These states are pursuing State Partnership Marketplaces.
Source: George Washington University analysis of state-based marketplace documents.

Appendix Table 2. Four States Have Essential Community Provider Standards Exceeding the Federal Minimum

State	No Additional Standards	Specific Provider Types Identified	Specific Geographical Access Measures	Expanding ECP Definition	Specific Participation Targets Identified
AR †	X				
CA		X	X		X
CO				X	
CT		X			X
DE †	X				
DC	X				
IL †	X				
IA †	X				
MD	X				
MI	X				
MN					X
NV	X				
NH †	X				
NM †	X				
NY	X				
OR	X				
VT	X				
WA	X				
WV †	X				

† These states are pursuing State Partnership Marketplaces.
Source: George Washington University analysis of state-based marketplace documents.

Appendix Table 3. Nine States and the District of Columbia Have Substitution Standards for Essential Health Benefits Differing from Federal Standards

State	Recites Federal Minimum or Is Silent	Prohibits Substitution	Permits Substitution with Variation
AR †	X		
CA		X	
CO	X		
CT		X	
DE †	X		
DC		X	
IL †			X
IA †	X		
MD		X	
MI		X	
MN	X (Silent)		
NV	X		
NH †	X		
NM †	X		
NY			X
OR	X		
VT			X
WA		X	
WV †			X

† These states are pursuing State Partnership Marketplaces.
Source: George Washington University analysis of state-based marketplace documents.

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