



About SERFF

The original concept for SERFF was developed in the early 1990s by the NAIC. The Electronic Filing Submission's intent was to provide a cost-effective method for handling insurance policy rate and form filings between regulators and insurance companies. In June 1996, the SERFF Consortium, an unincorporated group of interested states and companies, was formed in response to the demand for an automated system. SERFF has been an open, cooperative partnership with the mission to fund and oversee the development of the SERFF application from its beginning. This partnership has been very successful because this approach enables both the states and the industry to participate directly in decisions relating to the development and use of SERFF. This has allowed the states and companies to jointly exert a measure of control over a mission-critical function that otherwise could overwhelm either party's capability to respond to changing process requirements.

The SERFF system is designed to enable companies to send and states to receive, comment on, and approve or reject insurance industry rate and form filings. From November, 1996, through March, 1997, the Consortium membership met monthly in Chicago and Kansas City to define the requirements of the system. During these meetings, the membership resolved a number of issues -- particularly the issue related to a central repository of filings. The Consortium also selected Lotus Notes as the development technology. During the remainder of 1997, IESMidwest, a private sector software developer under contract to the NAIC, worked on writing the production SERFF system.

In early June 1997, members of the Consortium met in Kansas City to confirm the direction that IESMidwest was taking with the development effort and approve continuing the contract. Later in the month the SERFF Board of Directors met in Chicago during the NAIC Summer meeting (1997), to formally vote on continuing the project.

From October, 1997 through December, 1997 a pilot test was conducted. During this test, six states and ten companies tested the application in a production environment.

In December 1997, the consortium and the NAIC agreed that the NAIC would take over the operation of SERFF and the SERFF Board (representing the companies and states) would continue to formulate direction.

In 1999, the NAIC modified the SERFF infrastructure to allow the capability to remote host the SERFF system on a server located outside of an organization's network. States could then use SERFF without requiring huge amounts of technical support and investment costs.

During the summer of 1999, several important enhancements were noted and changed with a new SERFF release 1.4a, distributed to customers in September, 1999. The PSC, meanwhile, was evaluating the recent enhancements with the need for more functionality. One of the most influential impacts on SERFF was the decision that the system should be available as an Internet interface, with an anticipated completion date in late third quarter 2000.

Beginning in January 2000, Commissioner Nichols and the NAIC released a "Statement of Intent" that outlined changes that will be considered in the insurance regulatory environment. Part of this document addressed the "Speed-to-Market" issues that concern rate and form filings. Key accomplishments in the area of Speed to Market include the development and implementation of Uniform Product Coding Manuals (P-CM), Uniform Transmittals, Electronic Funds Transfer, and Standardized Filing Types. The Product Coding Manuals is a uniform product naming convention established to standardize lines of business. To date, 51 jurisdictions have implemented all 153 business areas (property, fire and health) and leverage the P-CM. The Uniform Transmittals have replaced all state specific transmittal letter requirements and have been implemented by 51 jurisdictions. In addition, all states that require fee remittance in advance of the review and approval of submitted filings now accept electronic payment via SERFF, thus further reducing the turnaround time for filings. Lastly, the states have adopted standardized filing types within SERFF, thus allowing industry users to more efficiently submit filings in multiple states simultaneously. These improvements in the product filing, review and approval, have significantly reduced filing turnaround. For the last 12 months, on a nationwide average basis, filer health filing turnaround is 47 days and property/casualty is 28 days.

The NAIC membership and industry representatives actively discuss how changes can be made in the regulatory arena to improve the process. SERFF continues to be the automated solution to efficient rate and form filing.

As of today, 49 states, the District of Columbia, Puerto Rico and over 3,400 insurance companies, third-party filers, rating organizations and other companies are committed to SERFF. Reflecting on the past 10 years, SERFF has experienced tremendous growth.

- 2001 – 3,694 Filings
- 2002 – 25,528 Filings
- 2003 – 76,932 Filings
- 2004 – 143,818 Filings
- 2005 – 183,362 Filings
- 2006 – 268,101 Filings
- 2007 – 381,377 Filings
- 2008 – 554,261 Filings
- 2009 – 527,199 Filings
- 2010 – 565,473 Filings
- 2011 – 556,669 Filings

The NAIC members encourage insureds to become active in a voluntary SERFF program that offers a technological solution to address rate and form filing and approval process. SERFF offers a decentralized point-to-point, web-based electronic filing system. SERFF facilitates communication, management, analysis and electronic storage of documents and supporting information. The system is designed to improve the efficiency of the rate and form filing and approval process and to reduce the time and cost involved in making regulatory filings. It also provides up-to-date filing requirements when they are needed.

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Multi-State Plans Under the Affordable Care Act¹
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Abstract

New state health insurance exchanges that are developing under The Patient Protection and Affordable Care Act (ACA) will offer consumers a choice of private health plans known as qualified health plans (QHPs). Under the law, in every state, two of those must be multi-state plans or MSPs. These plans will be administered by the federal Office of Personnel Management (OPM). The MSPs must meet the same requirements as other QHPs. As with other QHPs, people enrolled in the plans will be eligible for premium tax credits and cost sharing assistance if their income is less than 400 percent of poverty or \$92,200 for a family of four. OPM, which also administers the Federal Employee Health Benefits Plan, must administer MSPs separately and must contract with both a non-profit insurer and one that does not provide abortion coverage. OPM will negotiate premiums, set rates, establish medical loss ratios and profit margins as well as certify and de-certify plans and make sure they have adequate networks of providers. OPM is expected to release its proposed rule on the MSPs this spring. This paper, based on interviews with federal and state policy makers and others, examines key implementation issues.

Overview

In 2014, The Patient Protection and Affordable Care Act (ACA) will provide near universal health insurance coverage through a substantial expansion in Medicaid, premium tax credits that will cap premium contributions as a share of income for people purchasing private plans through new state insurance exchanges, and new insurance market rules that will prevent health insurers from denying coverage or charging higher premiums to people with preexisting health conditions. With some exceptions, all individuals will be required to obtain insurance coverage through employers, public programs, the individual market, or the health insurance exchanges for the individual and small group markets.

A primary goal of the law is to increase consumer choice by stimulating market competition among health plans to offer more affordable, value-based options through the new insurance exchanges. The state health insurance exchanges are designed to provide consumers choices among pre-approved health plans that meet certain federal standards ranging from the provision

¹ Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers or staff.

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of specific benefits to anti-discriminatory requirements for pre-existing health conditions.³ Only plans that meet these standards – the qualified health plans or QHPs – will be allowed to participate in the exchanges. To further foster competition, the ACA also requires two QHPs participating in each exchange to be multi-state plans or MSPs. Unlike other QHPs participating in state-based exchanges that will be regulated at the state level, the MSPs will be licensed by the states but regulated by the federal Office of Personnel Management (OPM), the same agency that is today responsible for the Federal Employees Health Benefit Plan (FEHBP).

What are the multi-state plans?

The ACA charges the Director of OPM to establish two MSPs and offer them through state exchanges – one plan must be offered by a non-profit organization and one plan must not provide abortion coverage. MSPs must meet the same federal requirements as other QHPs, including offering certain essential health benefits and setting premiums that do not discriminate based on pre-existing health conditions and other factors such as race and gender, as well as any additional state requirements (e.g., provision of additional essential health benefits at state option and cost). Individuals enrolled in an MSP are eligible for premium tax credits and cost sharing assistance just like the credits and assistance available through a QHP that is only offered in one state. However, unlike other QHPs, MSPs must offer uniform essential health benefits in every state in which they operate and be available in all geographic regions and in all states that adopted a community-based rating system for setting premiums prior to the passage of the ACA (e.g., rating systems that take into account the health of the entire population and not certain subgroups). As discussed further below, OPM will be responsible for contracting with and oversight of the MSPs rather than the states.

The MSPs will be phased in nationally and available in 60% of states in year one, 70% in year two, 85% of states by year 3 and all states in subsequent years. The MSPs must be separate from the FEHBP, with a separate risk pool. That is, the revenues from MSPs and the claims against those revenues to pay for care for MSP enrollees must be kept separate and distinct from the costs of FEHBP. The OPM Director may not take resources away from FEHBP, but may create separate offices to administer the MSPs. Health insurance companies or carriers participating in FEHBP cannot be required to participate in a MSP.⁴

OPM has a long track record in administering health plans. The FEHBP offers federal employees and retirees and their dependents coverage through over 200 plans. They include plans that are nationally available, local Health Maintenance Organizations (HMOs), and various high deductible and consumer driven plans across the country. OPM has been able to negotiate lower premium growth than other large employer purchasers.⁵

³ QHPs must be certified, comply with rules and regulations related to marketing, applications and notice, transparency, enrollment and termination and must offer at a minimum one silver and one gold plan. Patient Protection and Affordable Care Act § 1334, 42 U.S.C. § 18054 (2011).

⁴ §1334(g).

⁵ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-07-141, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: PREMIUM GROWTH HAS RECENTLY SLOWED, AND VARIES AMONG PARTICIPATING PLANS (2006).

Who has oversight for MSPs in the exchanges?

The OPM Director will contract with health insurance companies to offer MSP individual coverage and group coverage for small employers in exchanges for a one-year maximum term. This is different from the arrangements for other QHPs, which will contract directly with states. The MSP contracts will be automatically renewable for additional one-year terms. This approach is modeled on how OPM administers nationally available FEHBP plans.

MSPs must be licensed in each state and meet other state requirements similar to the intrastate QHPs, but it is the OPM Director that has general oversight of the MSPs. OPM will negotiate premiums, set profit margins, medical loss ratios, and other coverage terms with insurers and can prohibit them from offering plans that do not meet these terms. This is important because these are functions that states will carry out for other QHPs. OPM may go beyond state regulations to establish more rigorous review than states and to more actively pursue value-based purchasing or payment reform strategies, for example.

In addition, CMS has recently released rules⁶ governing state exchanges which further clarify that OPM will determine if MSPs meet all QHP standards and will certify, recertify, and decertify MSPs.⁷ OPM also will determine rates, transparency reporting, accreditation timelines and network adequacy standards for MSPs. In addition to exemption from state certification procedures for QHPs, MSPs are exempt from Exchange processes for receiving and considering rate increase justifications and for Exchange processes for receiving annual rate and benefit information.

Further, an MSP must meet specific requirements set by OPM and meet relevant state requirements. For example, consumers are protected if an MSP experiences difficulties. MSPs that are discontinued must credit contingency reserves to the contingency reserves of continuing plans for the contract term following termination. OPM has established regulations in the event that a plan discontinues prior to receipt of contingency fees owed due to discontinuance of a different plan.

Upon OPM approval, MSPs will be “deemed” eligible to participate in every state’s exchange – that is, a state exchange cannot deny consumers’ access to the two MSPs. This raises concern in some states as it will prevent states that may be pursuing value-based purchasing and selective contracting from eliminating MSPs that are not subject to state oversight as an option through their exchanges.

⁶ Department of Health and Human Services, CMS-9989-F: The Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (Mar. 12, 2012), http://www.ofr.gov/OFRUpload/OFRData/2012-06125_PI.pdf.

⁷ An insurer must receive notice and a hearing before the Director can revoke an approved contract. *Id.*

A level playing field

While providing for specific responsibilities to rest with the federal rather than state government, the ACA does require MSPs and other QHPS to operate on a “level playing field.”⁸ If the MSPs (or the Consumer Operated and Oriented Plan (Co-OP) also established by the ACA) are exempted from thirteen specific provisions in federal or state law, then private health insurers offering QHPs are also exempted. This assures that the MSPs meet the same minimum standards as all other QHPs.

Some fear that in order to negotiate lower rates for MSPs, the OPM could hold MSPs to lower standards than the state which would pre-empt state regulation for all plans. That is, if MSPs are held to lower standards, the level playing field language says that the OPM standards will effectively become the market standards in that state. The level playing field language then, gives assurances to states that OPM will comply with the following minimum standards or risk disruption in market oversight. Those standards include:

- guaranteed renewal
- rating
- pre-existing conditions
- non-discrimination
- quality improvement and reporting
- fraud and abuse
- solvency and financial requirements
- market conduct
- prompt payment
- appeals and grievances
- privacy and confidentiality
- licensure and benefit plan material or information

Nothing in the law prohibits MSPs from going beyond state minimum requirements. For example, OPM may wish to hold the MSPs to higher quality standards than other QHPs.

How can MSPs provide a uniform benefit in each state?

The federal government recently issued a bulletin that provides some state discretion in defining essential health benefits. Specifically, the bulletin requires that all plans sold through the exchanges and in the individual and small group markets must offer the ten essential health benefits defined in the law. States can choose a benchmark plan from among four choices. Those choices include 1) one of three largest plans sold in the small group 2) one of three largest plans in the state employee health plan 3) one of the three largest plans offered by the federal

⁸ § 1324.

employee health benefits plan or 4) the largest HMO in the commercial market.⁹ Allowing each state some discretion in defining the essential health benefit may complicate how MSPs could then offer a uniform benefit in every state, as required by law. Specifically, the law requires that “the plan offers a benefits package that is uniform in each state and consists of the essential health benefits....” Some read that language to mean plans must be uniform only in each, single state; others note that the language does not say uniform “within” each state and therefore believe that the law’s intent is to promote a single uniform benefit.

OPM seeks stakeholder guidance on implementation of the MSPs

OPM has reached out to stakeholders for guidance on how to best implement the MSPs. While the ACA calls upon the OPM Director to create an Advisory Board to provide recommendations about the MSPs, the composition of that Board must be enrollees of the plans or their representatives so the group cannot yet be convened. However, on June 16, 2011, OPM issued a Request for Information (RFI) to gather information on key implementation issues. In the RFI, OPM envisions establishing MSPs in much the way it operates the FEHBP, with annual negotiations of rates under a national contract. OPM anticipates having contracts in place with MSPs by October 2013.

The RFI was directed to health insurers and solicited feedback in five broad categories: background and interest; network and quality measures; enrollment and marketing; operations; and pricing and reserves. Responses were due August 2011 but that deadline was extended. OPM has responded to some questions raised through the RFI process but has not made responses public.

Although the RFI was directed to health plans, other organizations responded and have made their comments public. Notably, the National Association of Insurance Commissioners (NAIC) submitted lengthy comments critical of the plan, largely based on the potential to provide large insurers with significant, anti-competitive market share, opposition to deeming and concerns about appropriate safeguarding of consumer protection and state regulatory roles. NAIC also raised concerns about an uneven playing field, the potential for adverse selection and the impact on rates if MSPs are held to different rules as well as the potential to diminish a state’s value purchasing efforts by deeming plans in an Exchange. NAIC cautioned OPM not to engage the non-profits currently offering FEHBP coverage as they meet different solvency standards than commercial carriers are held to by the states.¹⁰

The American Medical Association also made public comments to OPM, echoing some of the concerns of NAIC regarding the level playing field and the need for consumer protection,

⁹ December 16, 2011, the HHS Center for Consumer Information and Insurance Oversight (CCIIO) released an Essential Health Benefits Bulletin with comments due by January 31, 2012.

¹⁰ Letter from National Association of Insurance Commissioners to Cheryl Allen, United States Office of Personnel Management (Aug. 10, 2011), http://www.naic.org/documents/committees_b_110810_naic_comments_msp_to_opm.pdf.

network adequacy and prompt payment protections.¹¹ The AMA called upon OPM to hold MSPs to standards, articulated in the AMA Health Insurer Code of Conduct Principles, that are higher than the baseline included in the ACA.

OPM is currently reviewing comments and deliberating questions about the MSPs in anticipation of rulemaking in the spring of 2012.

Potential Opportunities and Challenges for MSPs

As OPM moves through the rulemaking process and toward implementation of MSPs, there are a number of opportunities and challenges that OPM and stakeholders will need to consider.

Potential Opportunities

Will MSPs provide more competition and consumer choice?

The availability of two MSPs in every exchange by 2017 can significantly increase plan choices for consumers in the exchanges. For the many states with consolidated markets, MSPs could be uniquely positioned to expand competition. However, the potential for new covered lives through the individual mandate and premium and cost sharing tax credits may not be enough to increase competition in markets that are highly concentrated and have long been unattractive for insurers.

The median market share of the largest insurer in the individual market was 54% (and 51% in the small group market) in 2010.¹⁰ In eleven states the largest insurer has over 73% of market share in the individual market and in ten states one insurer holds 67% or more of the market share in the small group.

In short, in seventeen states one insurer holds at least 67% of market share in either the individual or small group markets or both. These states are disproportionately small and rural and include: Louisiana, Mississippi, Alabama, Tennessee, South Carolina, Maryland, Rhode Island, Montana, South and North Dakota, Arkansas, Kentucky, North Carolina, Virginia, New Jersey, Iowa, and Vermont. For these states, the availability of an MSP may be the only assurance of increased competition. But, to meet that goal of increased competition, who would that MSP be? The GAO recently surveyed states regarding the small group market. Fourteen of the seventeen states reported above responded to the survey; in thirteen, a Blue Cross Blue Shield plan was the single largest carrier and, on average, held about 60% of the market share.¹²

Blue Cross Blue Shield plans are significant players in the individual and small group markets and many are non-profit. If they are selected as the non-profit MSP, the result could be further

¹¹ Letter from James Madara, M.D., CEO, American Medical Association to Cheryl Allen, United States Office of Personnel Management (Sep. 6, 2011); KAISER FAMILY FOUNDATION, HOW COMPETITIVE ARE INSURANCE MARKETS?, (2011) <http://www.kff.org/healthreform/upload/8242.pdf>.

¹² U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-09-363R, PRIVATE HEALTH INSURANCE: 2008 SURVEY RESULTS ON NUMBER AND MARKET SHARE OF CARRIERS IN THE SMALL GROUP HEALTH INSURANCE MARKET (2008).

market consolidation, rather than increased competition. Generally, Blues plans operate within their own geographic service areas. This suggests that, in those states where a for-profit Blues plan holds significant market share, a non-profit plan other than a Blues plan would be required to assure an MSP that could bring added competition.

As OPM contemplates how best to phase in the MSPs, it might consider including these states with highly concentrated markets in the first wave of implementation.

How will MSPs and federally facilitated exchanges operate?

Only fifteen states have enacted legislation or are operating under a Governor's executive order to create an exchange, either for the individual market or the SHOP exchange for small business. While states are making progress, it seems likely that the federal government will be deeply engaged in federally facilitated exchanges in 2013-14. There may be additional opportunities for the federal government to coordinate the offer of MSPs with their own exchange development. For example, in those states that do not enact legislation to establish exchanges by 2013, it is possible that they likewise may not enact the insurance reforms required in the ACA. Although states have been actively engaged in enacting the early insurance reforms, such as elimination of lifetime benefits and mandating coverage of young adults on parents' plans,¹³ some states may be unable or unwilling to enact guaranteed issue and community rating requirements in time for ACA implementation. Those provisions will need to be in effect by late 2013 in order to begin marketing under the ACA. In that instance, responsibility to assure marketplaces are in compliance with the law will fall to federal officials. That regulatory role, coupled with a federally facilitated exchange, may provide opportunities for the federal government to include MSPs in those marketplaces and to make them market leaders

Can MSPs be a high value option?

OPM will negotiate nationally and can, through its premium setting and other authorities, negotiate for high value plans. The language that assures MSPs operate on a level playing field and meet the same general rules that other plans meet does not preclude an MSP from going beyond those minimums. For example, they may elect to hold MSPs to higher quality standards. Because the federal government will establish network adequacy standards for MSPs, there may be opportunities for selective contracting with providers who meet higher quality standards. MSPs with the same benefits, operating through one contract from OPM and the reporting and oversight it provides, could be a model engaging in national marketing, quality and consumer information efforts. The plans offered as MSPs could become national benchmarks of quality performance.

The National Committee on Quality Assurance (NCQA) issued a "Value Agenda for Health Plans" in its 2011 annual report. It identifies five broad categories for plans to follow to achieve

¹³ KATIE KEITH, KEVIN LUCIA & SABRINA CORLETTE, THE COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: STATES ACT ON EARLY MARKET REFORMS (2012)
http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Mar/1586_Keith_state_action_early_market_reforms_v2.pdf.

high value. Those include fostering delivery system reform; designing benefits and reimbursement strategies that improve health and reduce ineffective care; collecting and publically reporting performance data; and establishing provider networks that use value metrics and support centers of excellence and activating patients, including in health promotion and end of life care. OPM could negotiate with plans and use its authorities to establish rates and define network adequacy, for example, to select plans as MSPs that best demonstrate a value agenda at an affordable price.

Can MSPs offer greater portability-coverage that travels with enrollees?

Americans are a mobile society and might value a plan that moves with them. Families may include students or spouses who live and work in different states and may now be required to participate in different health plans. Young adults may be more inclined to purchase coverage that was designed to meet their needs and pocketbook.

An MSP could offer continuity of coverage and assure a family that all its members could be covered in one plan, regardless of their state of residence. The ACA requires the creation of catastrophic plans for young adults, exempt from the essential health benefit definition that may vary by state. As such, a young adult product could be a starting point for MSPs.

Could federal agencies work creatively to expand Medicaid and exchange collaboration?

Significant numbers of exchange enrollees will experience income fluctuations that will cause them to churn between Medicaid and subsidy eligibility through the exchanges. Low-income Americans often have fragile and erratic connections to the workplace and see their incomes vary significantly throughout the year. Based on historical data, within six months, more than a third of all adults (age 19-60) with family incomes below 200% of the federal poverty level might be expected to experience income fluctuations that might change their eligibility from Medicaid (for families with incomes under 133% of poverty) to subsidized private coverage through the insurance exchanges or the reverse.¹⁴ The potential for these enrollees to fall through the cracks, lose needed coverage or be required to change provider networks as their coverage changes will create further administrative challenges for both Medicaid and the private plans in the exchange. If a health plan, either directly or in collaboration with others, agrees to participate in a state's Medicaid program, enrollment can be seamless and continuity of coverage and care assured, should a state choose to contract with that plan. A member who loses Medicaid or who loses tax subsidies because of Medicaid eligibility could stay in the same plan with the same providers; a back office function could assure the proper allocation of costs between Medicaid and private coverage, given that two distinct payers will need to be coordinated.

The ACA's provision, that those newly eligible for Medicaid may be offered a plan more like a commercial product than most Medicaid benefits, provides additional opportunity for health plans, including MSPs. But each state Medicaid program will have unique attributes and the

¹⁴ Benjamin Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Health Insurance Exchanges*, 30 HEALTH AFF. 228 (2011).

churning between the tax credits and Medicaid will not be limited to those newly eligible. That raises issues about how best to coordinate the two programs through the MSPs.

Of course the challenges of incentivizing any plans, including the MSPs, to enroll Medicaid members are significant. Different payers, payment rates, provider networks and benefit packages as well as the possibility of a new Basic Health Plan that will cover those above Medicaid eligibility but below 200% of the federal poverty level, need to be considered. But the MSPs may create a unique opportunity to address the problem of churning between Medicaid and subsidies, either directly or through subcontracts with more established Medicaid managed care plans. And the sister federal agencies of OPM, the Centers for Medicare & Medicaid Services (CMS) and Center for Consumer Information and Insurance Oversight (CCIIO) may be able to collaborate to facilitate innovation over time.

OPM, working with CMS, CCIIO and the states, could establish incentives for MSPs to operate in both the subsidy and Medicaid markets. The OPM RFI suggests such an interest and asks for related information and possible partnerships with community health plans and Medicaid plans.

Is there an opportunity to expand health insurance options?

OPM could encourage the formation of new health plans or collaborations between carriers and community health plans or Medicaid managed care plans. Could the Consumer Operated and Oriented Plans (Co-Ops),¹⁵ established under the ACA, organize to become an MSP? The ACA includes specific provisions¹⁶ that would allow plans operating within states to form regional or national affiliations to become MSPs; however Co-Ops are only now beginning to form and may not be ready to organize together as an MSP consistent with the law's timetable.

Can MSPs help transition Members of Congress and their staffs to ACA coverage?

The law requires Members of the Congress and Congressional staff to receive health coverage through health plans that are created by the ACA or offered through a newly authorized state or federal based exchange.¹⁷ Their health coverage is currently provided through the FEHBP administered by OPM. However, the law does not identify an administering entity or implementing authority responsible for making this transition.

The conversion of Members of Congress and their staffs from FEHBP to an Exchange raises a number of issues such as whether and how the Federal government will pay premiums, which Congressional staff are included in the new health plan provisions, and whether the FEHBP plan will be considered a "grandfathered plan"- that is one that is able to continue to offer coverage

¹⁵ ACA §1332 establishes a program to facilitate the creation of not-for-profit consumer operated health plans for offer in state Exchanges and permits CMS to award loans to eligible start-ups.

¹⁶ Patient Protection and Affordable Care Act § 1334(a)(1), 42 U.S.C. § 18054(a)(1) (stating "health issuers may include a group affiliated either by common ownership and control or by the common use of a nationally licensed service mark.").

¹⁷ § 1312(d)(3)(D).

without complying with all provisions of the ACA.^{18,19} Resolving these issues will require considerable engagement of OPM staff.

The MSPs may provide a logical vehicle for this transition. While the ACA is clear that OPM must maintain discrete staffing and risk pools for FEHBP and the MSPs, it would seem reasonable to coordinate the conversion from FEHBP through the new MSP office. Because OPM will administer the MSPs, they seem a logical vehicle for providing the mandated coverage of staff and Members of Congress and coordinating the financial participation of the Federal government toward the cost of coverage.

Challenges for MSPs

Why would health plans seek to become MSPs?

New opportunities exist under the ACA for health plans to expand markets to people who will become newly insured under the law's insurance expansions. The question is will insurance carriers want to become MSPs, when they can simply participate directly in the exchanges? OPM may attract national firms to become MSPs by providing national marketing assistance; assuring one contract rather than state by state negotiations; experimenting with different pooling and risk arrangements and otherwise streamlining administrative procedures and costs.

Will MSPs create adverse selection?

The law gives significant authority to OPM to set rates, determine network adequacy and otherwise certify and regulate MSPs differently than the state. While the plans will need to comply with the level playing field rules and comply with state licensure rules, it is possible for OPM to meet that benchmark and still design a unique product in the market.

MSPs will need to attract providers and, in many markets, those provider networks are highly consolidated. It is unclear what incentives providers will have to negotiate rates with MSPs. OPM holds the authority to establish network adequacy standards. If OPM cannot secure competitive rates from providers, they may be able to establish payment reform strategies or define network adequacy standards to achieve more competitive rates, assuring a smaller number of providers receive a larger market share.

If an MSP is a high value plan – offering better services than other QHPs in the exchange- it could attract a disproportionate enrollment of unhealthy people who require more care; if the plan is able to underprice the competition, it could attract a disproportionately healthy

¹⁸ JENNIFER STAMAN, EDWARD LIU, ERIKA LUNDER, & KENNETH THOMAS RESEARCH SERV., M-042910, QUESTIONS REGARDING EMPLOYER RESPONSIBILITY REQUIREMENTS AND SECTION 1312(D)(3)(D) OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010).

¹⁹ JENNIFER A. STAMAN & TODD B. TATELMAN, RESEARCH SERV., M-040210-A ANALYSIS OF § 1312(D)(3)(D) OF PUB. L. NO. 111-148, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AND ITS POTENTIAL IMPACT ON MEMBERS OF CONGRESS AND CONGRESSIONAL STAFF (2010).

population. That market segmentation could result in a disproportionate enrollment of healthy people in the MSP and a cost increase in other plans. Alternatively, if the MSP provided richer benefits than others in the market, the MSP could effectively become a high risk pool, attracting the sickest and those most in need of richer benefits. Finally, if the MSP were a young adult only plan, the state's risk pool would be negatively impacted by the loss of young, healthy lives.

However, the ACA requires provisions to mitigate risk selection, including a permanent mechanism of risk adjustment and two temporary measures, risk corridors and reinsurance, designed to avoid the scenarios described above. Risk adjustment requires payment adjustments relative to the risk of a plan's covered lives. Risk corridors protect against inaccurate cost estimates in the first three years and funding for reinsurance protects against very high-cost enrollees. With the exception of funding for reinsurance, the cost of these provisions is generally born by insurers. States, however, seek assurances that MSPs will participate in these programs and in their costs.

Because the OPM will develop medical loss ratios and negotiate premium rates and standards for network adequacy, MSPs will be held to different standards that could affect state markets. How MSPs will affect broader markets remains an important concern, particularly for the states. While it is unlikely that OPM will hold MSPs to different medical loss ratios, they will likely vary in terms of premium rates and network adequacy standards based on the multi-state nature of the MSPs. While this could make the MSPs highly competitive, it also could be disruptive to the underlying state-based exchange market driving QHPs out of the market if they can't compete with the more favorable terms provided to MSPs that allow them to offer lower premiums or a broader network.

Do MSPs limit opportunities for states to establish exchanges that are active purchasers of health care and conflict with state oversight responsibilities?

The ACA allows states to establish state specific standards for QHPs that exceed federal minimums in areas such as benefit design, number of available plans in the exchange, and contracting periods. It also requires MSPs to be licensed and subject to requirements in state law. Even if an MSP complies with state laws, exchanges may wish to selectively contract among available plans. For states that wish to selectively contract for health plans in the exchange, this provision that automatically qualifies MSPs to participate in an exchange makes it impossible to exclude an MSP that does not meet higher state purchasing standards. This could minimize the effectiveness of value-based purchasing in exchanges.

The creation of MSPs challenges established state insurance regulation and consumer protection, although it is modeled after existing nationwide plans in the FEHBP. Those plans, for example, are exempt from state mandates and state premium taxes. The NAIC, noted earlier, has raised significant concerns about the potential conflict between MSPs and state regulatory responsibilities. The ACA explicitly requires the OPM Director to negotiate with each MSP the medical loss ratio, premiums and profit margin and such other terms and conditions as are in the interest of enrollees, while states retain authority for an array of regulations including licensing and solvency.

It remains unclear how MSPs will be treated regarding risk sharing, risk corridors and reinsurance, and who pays. Given there is a possibility that MSPs might disrupt markets and create adverse selection, that potential could be ameliorated by the ACA's provision to protect against selection bias through these risk arrangements. States make clear that markets are local, risk must be born locally and MSPs must be regulated locally and comply with all state laws, as articulated in the "level playing field" language. Additionally, states need assurances regarding how MSPs will participate in the exchanges and that they will pay whatever fees may be assessed on health plans to maintain the exchanges.

Does the insurance industry have adequate capacity to launch MSPs?

While several major carriers are licensed in each state today, any new offering requires state action and companies would need to build capacity and provider networks where they may be licensed but not active. And those companies may be offering products only in the large group, and have long been reluctant to expand their offerings into the individual and small group markets. Still, a company that is already operating and licensed in the large group in a state has provider networks which could make it easier to enter the individual and small group markets and meet network adequacy standards.

The requirements to comply with multiple and potentially conflicting state insurance, OPM, and exchange rules are disincentives for plan engagement. The industry, like the states, is already grappling with the myriad of ACA requirements implementation and consideration of an MSP may not be a high priority for many of them. The requirement to be operational in 60% of states by 2013 is daunting. Some companies may be interested in a truly national plan, with a national medical loss ratio that operates more like the FEHBP, exempt from much state regulation.

Discussion

The law requires OPM to enter into contracts with health insurance issuers to offer "at least 2 multi-state qualified health plans through each exchange in each state"²⁰ and requires those plans to offer a benefits package that is uniform in each state. On its face, this suggests the availability of fully portable health plans nationwide. One plan must be a non-profit entity; another must not offer coverage for abortion services. The law spells out clear authorities for OPM to negotiate many of the conditions of coverage even while requiring the plans to be licensed and comply with laws in each state. It authorizes OPM to contract with issuers or with a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark. Finally, the law phases in nationwide coverage, requiring plans to operate in at least 60 percent of states in the first year.

Such a plan could provide added value in states that are not ready to implement exchanges by 2014. It appears today that many states will be unable to have fully operational exchanges that meet federal timelines. Those states may not yet have enacted the insurance reforms in the individual and small group markets required by the law. In those instances, the federal

²⁰ § 1334(a)(1).

government will enforce the insurance requirements directly and establish federally facilitated exchanges. An MSP in that scenario might serve as a bridge to state readiness.

Importantly, the ACA does not use the term “national plan” but instead consistently refers to “multistate plans.” The ACA already includes controversial provisions to allow states to enter into compacts²¹ that allow health plans to be sold in more than one state subject only to the laws of the state where it was issued. Even here, however, the law requires the issuer to be licensed in each state and to meet each state’s unfair trade practices and consumer protection laws. The compacts must be enacted by state legislatures and approved by the Secretary. Unlike the MSPs, compacts cannot be implemented until 2016. And, unlike the compacts, the MSP is administered by OPM and one plan must be a non-profit.

OPM has a long track record in performing exchange-like activities – selecting and contracting with multiple plans, negotiating rates and informing consumers about their choices. As such, the OPM may be uniquely qualified to develop new and discrete MSPs that are value based and could be market leaders in cost and quality. But many issues must be resolved including attracting plans to the MSP market; the impact of MSPs on state markets and state insurance regulation and on the capacity of exchanges to administer and compare plan offerings that are accountable to different entities and different rules.

OPM will need to address whether and how an MSP provides added value, particularly to attract insurers, and determine how to phase in MSPs to assure they are available to 60% of states in 2014 and to all states by 2017. State marketplaces are heterogeneous. In some states, the marketplace is robust; in others there is little or no competition. Generally, states will fall into several broad categories:

1. States on target to develop exchanges by 2013:
 - A. With competitive markets who are designing exchanges to be active and selective purchasers
 - B. With competitive markets who are designing open exchanges
 - C. With consolidated markets and little competition
2. States not on target to fully implement exchanges by 2103.

For states in competitive markets that are building exchanges designed to negotiate for price and quality, the requirement to deem MSPs eligible to offer products in the exchange conflicts with those state goals. The law requires plans to be licensed in the state and to comply with state laws not inconsistent with the MSP provisions, but that does not assure that all plans will meet the standards established in a value purchasing exchange.

It is unclear how many states will establish exchanges that wish to be value purchasers and selectively contract with plans. To avoid conflicting with those that do, OPM, either directly or

²¹ § 1332(a) (1)-(4).

through statutory change, could articulate a standard that defines a competitive market and exempt those states from MSP requirements. Or, a state that has a competitive market could be deemed in compliance with the law and exempt from the requirement to offer an MSP.

However, in most states, the individual market and often the market for small business, is highly consolidated. The MSP could focus on those states where competition is limited and where the MSP might offer competition and choice. At least some states may find themselves developing exchanges but unable to attract insurers to offer adequate options within them, even with an individual mandate and the availability of subsidies. If that proves to be the case, the MSP could provide an important option. It may be in these states, and states where a federally facilitated exchange will be required in 2014, that MSPs should first be offered.

The MSPs provide consumers with more choice and present the opportunity to create high value plans. While concerns about the impact of MSPs on state markets have been well articulated by NAIC and others, MSPs may also help create markets that drive all insurers to develop competitive plans.

Looking forward

MSPs are a requirement of the ACA and OPM will soon issue proposed rules governing them. However, there is opportunity and time for states, insurers, advocates and other interested parties to contemplate whether and how MSPs could advance the goals of affordable, quality health care.

Preemption and State Flexibility in PPACA

The Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148) greatly expands federal involvement in health insurance oversight, introducing new federal minimum standards that will extend guaranteed issue to the individual market, require the use of adjusted community rating, prohibit pre-existing condition exclusions, limit rescissions, and require adherence to minimum loss ratios, among others. As the process of implementing the statute moves forward, it will be critical for states to understand how the federal law interacts with their own statutes and regulations.

Overview

Title I of PPACA, which includes most of the new federal standards that relate to health insurance coverage, contains the following provision:

No Interference With State Regulatory Authority—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.¹

This provision mirrors provisions in HIPAA that amended the Public Health Service Act and ERISA,² effectively allowing states to adopt and enforce laws and regulations that afford greater consumer protections while ensuring a basic level of protections across the country. In practice, this means that, beginning on the effective date for each provision, any state law that does not meet the federal minimum standards will be preempted, and the federal Department of Health and Human Services will assume regulatory authority for that provision of federal law. If a state already has a requirement that at least meets the federal standards, or adopts one in the future, then it would retain the authority to enforce it. For example, PPACA requires that insurers in all markets comply with adjusted community rating standards with a maximum variation for age of 3:1.³ Most states do permit the use of health status and allow greater variation for age than the federal standards allow, preventing the application of the federal requirements. States that adopt the new federal standards by 2014, when the federal rating rules take effect, will retain the ability to enforce their new rating rules, as would states that adopt more stringent standards, such as pure community rating.

Other provisions of the legislation create new programs to help people access health insurance coverage, such as temporary high risk pools and health insurance Exchanges.⁴ These programs are, where possible, implemented at the state level, with a federal fallback to ensure that are available in states that decline, or are unable, to implement them. HHS Secretary Kathleen Sebelius sent a letter to every state on April 2nd asking them to provide an initial declaration of their intent to apply for federal funds to operate the high risk pool program, or whether they would prefer for the federal government to operate the program directly in their state. Similarly, PPACA envisions health insurance Exchanges developed and operated by the States. The Secretary will determine in January 2013 which states are on track to operate health insurance Exchanges that meet the standards specified in the law. If she determines that a state has not made sufficient progress toward this end, or if it decides not to operate an Exchange, the federal government will contract with a nonprofit entity to operate an Exchange in that state.

Specific Areas of Preemption

PPACA also contains a number of other provisions that specifically preempt different types of state law.

¹ §1321(d)

² Public Health Service Act §§2723(a), 2746(a); Employee Retirement Income Security Act §704(a)

³ PHSA §2701, as added by PPACA §1201

⁴ §1101

⁵ §1311-1324

Grandfathering: The law requires all non-grandfathered health plans to maintain a single risk pool for each of the individual and small group markets. It also specifies that any state law requiring insurers to include grandfathered plans in these pools is preempted.

Multi-State Plans: The law also creates new multi-state plans overseen by the U.S. Office of Personnel Management, the agency that administers the Federal Employees' Health Benefits Program (FEHBP). These plans will eventually be sold through the Exchanges in every state. While states may require that these plans comply with mandated benefits laws, any state laws that do not apply to FEHBP plans will not apply to multi-state plans either.

Interstate Compacts: Beginning in 2016, two or more states may enter into interstate compacts to facilitate the sale of health insurance policies across state lines. Insurers would be able to sell policies in all compacting states using the laws and regulations of a primary state. Certain consumer protection laws in the purchaser's home state would continue to apply, however.

State Flexibility

PPACA also contains a number of provisions that provide states with the opportunity to take advantage of some additional flexibility. The first of these provisions allows states to establish "Basic Health Programs" to provide coverage to individuals between 100% and 200% of the federal poverty level*. This coverage could be provided by private carriers under a contract with the state using funds that otherwise would have been provided to these individuals as subsidies through the Exchange. If a state elects to offer a basic health program, those between 100% and 200% of the federal poverty level would no longer be eligible to purchase coverage through the Exchange.

The second provision would, beginning in 2017, allow states to apply to the Secretary of HHS for waivers of requirements for:

- Plans offered through the Exchange
- Administration of the Exchange
- Reduced cost-sharing in plans offered through the Exchange
- Premium subsidies
- Employer and individual mandates

States applying for these waivers must provide coverage at least as comprehensive as what would be offered through the Exchanges using funds that would otherwise be provided to state residents as tax credits or subsidies.

* §1331

Quality Activities in a Federally-facilitated Exchange



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS for MEDICARE & MEDICAID SERVICES
Center for Consumer Information and Insurance Oversight

Health Insurance Exchange System-Wide Meeting
May 21-23, 2012

QHP Certification Requirements *

Reporting Requirement	Reporting Begins
Quality Improvement Strategy Measures	Established in future guidance
Plan Performance Measures	Established in future guidance
Pediatric Performance Measures	2016
Enrollee Satisfaction Survey Implementation	2016
Quality Rating Measures	2016
Patient Safety	Established in future guidance
Accreditation	See next slide

*HHS intends to propose these in future rulemaking

Accreditation Requirement *

Certification Year	QHP Issuers Without Existing Accreditation	QHP Issuers With Existing Commercial/Medicaid Accreditation in the State
Year 1 (2013)	Schedule Accreditation Review	Attest that Accredited Policies and Procedures Comparable to QHP
Years 2 and 3 (2014 & 2015)	Accredited QHP Policies and Procedures	Attest that Accredited Policies and Procedures Comparable to QHP
Year 4 (2016)	QHP product type is accredited; QHP product type performance data has been submitted	

Note that in Years 1-3, issuers will also need to attest that they will submit performance data on the QHP product type when these data are available.

Partnership States must follow the same accreditation timeline.

** HHS intends to propose this timeline in future rulemaking*

Accreditation Verification

- An FFE will verify accreditation status with NCQA and URAC*
- Issuers must authorize the release of accreditation data from the accrediting entity
- Accrediting entities will send data to an FFE, including CAHPS results (if available)

**HHS intends to propose in future rulemaking that NCQA and URAC be recognized as accrediting entities for the purposes of QHP certification. The rulemaking will recognize NCQA and URAC as accrediting entities for QHP's in all Exchanges, whether State-based or Federally-Facilitated.*

Quality Display in an FFE

2013-2015

- Display set of composite CAHPS measures administered as part of existing NCQA accreditation
- Map CAHPS results from commercial and/or Medicaid product lines to the same QHP product types and adult/child populations
 - HMO Adult CAHPS → HMO QHP
 - PPO Adult CAHPS → PPO QHP
 - Child HMO CAHPS → Child Only HMO QHP
- FFE States can also choose for a link to existing quality data (such as health plan report cards) to be displayed

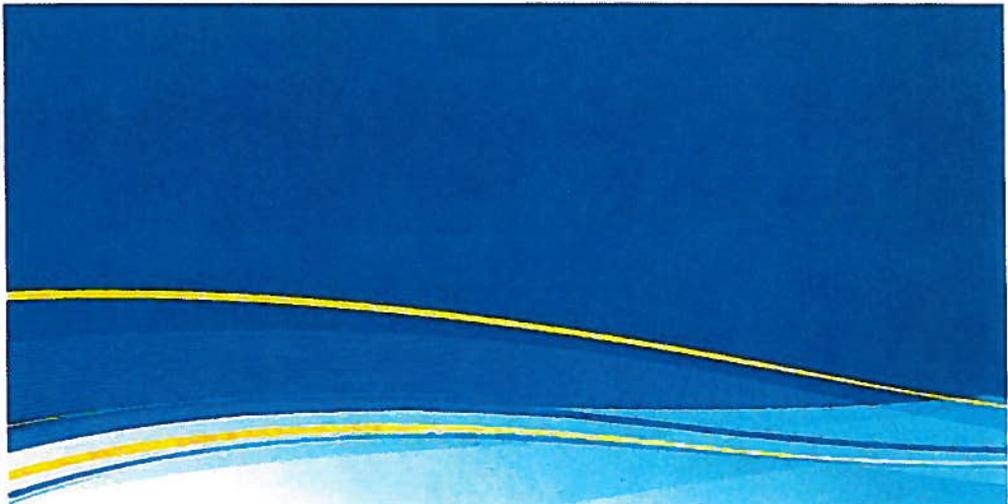
2016+

- Quality Rating*
 - Enrollee Satisfaction Survey (ESS) Results*
- HHS will support all Exchanges in calculating the quality rating and ESS.*

**HHS intends to propose these in future rulemaking*



Quality Reporting and Display Discussion Session



National Quality Strategy

Three Aims:

- **Better Care:** Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

Six Priorities:

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family are engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

Available at:

<http://www.healthcare.gov/law/resources/reports/quality03212011a.html>



Newsroom

New Loan Program Helps Create Customer-Driven Non-Profit Health Insurers

The Affordable Care Act creates a new type of private nonprofit health insurer, called a Consumer Operated and Oriented Plan, or “CO-OP.” CO-OPs are directed by their customers and designed to offer individuals and small businesses more affordable, consumer-friendly and high quality health insurance options.

The CO-OP program offers low-interest loans to eligible nonprofit groups to help set up and maintain these issuers. To date, a total of 23 non-profits offering coverage in 23 states have been awarded \$1,820,573,884.

Starting January 1, 2014, CO-OPs, will be able to offer health plans through the new, competitive health care marketplaces in their state, called the Affordable Insurance Exchanges. In addition to offering health plans through an Exchange, CO-OPs may also offer health plans outside of an Exchange.

The first round of applications was due on October 17, 2011, the second round of applications was due on January 3, 2012, the third round of applications was due on April 2, 2012, the fourth round of applications was due on July 2, 2012, and the fifth round of applications was due on October 1, 2012. The next quarterly application deadline is December 31, 2012. Awards will be announced on a rolling basis.

CO-OP loans are only made to private, nonprofit entities that demonstrate a high probability of financial viability. All CO-OPs receiving loans were selected by CMS on a competitive basis based on external independent review by a multi-disciplinary team. As CO-OPs meet or exceed developmental milestones, funds are allowed to be incrementally drawn down.

CMS will closely monitor CO-OPs to ensure they are meeting program goals and will be able to repay loans. To ensure strong financial management, CO-OPs are required to submit quarterly financial statements, including cash flow and enrollment data, receive site visits, and undergo annual external audits. This monitoring is concurrent with the financial and operational oversight by state insurance regulators.

For more information on CO-OPs, including what federal loans are available, who can apply and licensing requirements, please visit: http://cciio.cms.gov/resources/factsheets/coop_final_rule.html

Detailed below is some additional information about the new awardee:

Coordinated Health Plans of Ohio, Inc.

Service Area: Ohio

Award Amount: \$129,225,604

Award Date: October 12, 2012

Coordinated Health Plans of Ohio, Inc. (CHP-OH) is sponsored by Community Health Solutions of America LLC, an organization that develops healthcare delivery networks and systems to improve primary care. CHP-OH plans to provide statewide coverage in Ohio with the mission of offering health insurance that delivers high quality health care to citizens throughout the state.

In addition to this new award, the following applicants were awarded CO-OP loans in previous rounds:

Compass Cooperative Health Network

Service Area: Arizona

Award Amount: \$93,313,233

Award Date: June 8, 2012

Compass Cooperative Health Network (CCHN) is sponsored by prominent local experts in insurance, chronic disease coordination, use of health information technology to better coordinate care, and business startup. Compass Cooperative Health Network (CCHN) plans to offer health insurance coverage statewide over time in Arizona.

Colorado Health Insurance Cooperative, Inc. (CHI)

Service Area: Colorado

Award Amount: \$69,396,000

Award Date: July 27, 2012

The Colorado Health Insurance Cooperative, Inc. (CHI) is sponsored by the Rocky Mountain Farmers Union Educational and Charitable Foundation, Inc. (RMFU Foundation), which houses educational and outreach programs, and a regional cooperative development center. A significant component of CHI's plan is to create chapters in communities throughout the state in an effort to fully engage members in the business of the CO-OP. CHI intends to offer benefit plans designed for individuals and employers inside and outside the Colorado Health Benefit Exchange. The CO-OP is committed to offering a qualified health plan at the Silver and Gold benefit levels in both the individual and Small Business Health Options Program (SHOP) Exchange markets. CHI also plans to offer at least one Value Based Plan (VBP) in the small group market. CHI is planning on marketing its insurance programs on a state-wide basis.

HealthyCT

Service Area: Connecticut

Award Amount: \$75,801,000

Award Date: June 8, 2012

HealthyCT is sponsored by the Connecticut State Medical Society (CSMS) and the CSMS-IPA (a statewide Independent Practice Association), and plans to offer high-quality, coordinated medical care with strong physician-patient relationships at its foundation. HealthyCT will encourage the use of patient-centered medical homes in providing health insurance coverage statewide.

CoOpportunity Health (formerly Midwest Members Health)

Service Area: Iowa and Nebraska

Award Amount: \$112,612,100

Award Date: February 21, 2012

CoOpportunity Health is sponsored by the Iowa Institute, a community organization. They plan to provide health insurance coverage throughout Iowa and Nebraska.

Kentucky Health Care Cooperative

Service Area: Kentucky

Award Amount: \$58,831,500

Award Date: June 22, 2012

Kentucky Health Care Cooperative is sponsored by a coalition of business leaders, providers and community organizations who plan to improve health outcomes throughout the Commonwealth of Kentucky by providing better access to high quality care at an affordable cost. The Cooperative will participate in Kentucky's Health Insurance Exchange, as well as in the individual and small group marketplace.

Louisiana Health Cooperative, Inc.

Service Area: Louisiana

Award Amount: \$65,040,660

Award Date: September 28, 2012

Louisiana Health Cooperative, Inc. (LAHC) is sponsored by a coalition of providers and business leaders, including Ochsner Health System, who plan to improve health outcomes by providing better access to high quality care at an affordable cost. LAHC plans to provide statewide coverage in Louisiana with the mission of serving their members by promoting and supporting the delivery of integrated healthcare in each of their products and services. LAHC will participate in the individual and small group Health Insurance Exchanges operating in Louisiana, as well as in the health insurance marketplace.

Maine Community Health Options (MCHO)

Service Area: Maine

Award Amount: \$62,100,000

Award Date: March 23, 2012

Maine Community Health Options is sponsored by Maine Primary Care Association, which is a membership organization comprised of Maine's community, tribal, migrant, and homeless health centers.

Evergreen Health Cooperative Inc.

Service Area: Maryland

Award Amount: \$65,450,900

Award Date: September 28, 2012

Evergreen Health Cooperative, Inc. (Evergreen) plans to provide high quality, affordable care to Maryland residents while pioneering innovative forms of healthcare delivery. Evergreen intends to provide health insurance coverage statewide and in the Maryland Health Benefit Exchange

Minutemen Health, Inc.

Service Area: Massachusetts

Award Amount: \$88,498,080

Award Date: August 31, 2012

Minuteman Health, Inc. (MHI) is sponsored by Tufts Medical Center and Vanguard Health Systems, two hospital systems that intend to participate in the MHI network. MHI's mission is to deliver efficient, quality healthcare financing to their future membership. They propose to initially provide regional coverage in eastern and central Massachusetts and expand to offer statewide coverage by July 2014.

Michigan Consumer's Healthcare CO-OP

Service Area: Michigan

Award Amount: \$71,534,300

Award Date: May 18, 2012

Michigan Consumer's Healthcare CO-OP is sponsored by a coalition of 15 county health plans, which are private, non-profit corporations that provide a limited health coverage benefit to low-income individuals in Michigan. Michigan Consumer's Healthcare CO-OP plans to provide health insurance coverage statewide.

Montana Health Cooperative

Service Area: Montana

Award Amount: \$58,138,300

Award Date: February 21, 2012

Montana Health Cooperative is sponsored by a coalition of small businesses and community leaders and plans to add a strong primary care capacity to Montana's rural and medically underserved communities. Montana Health Cooperative will provide health insurance coverage statewide.

Hospitality Health CO-OP

Service Area: Nevada

Award Amount: \$65,925,396

Award Date: May 18, 2012

Hospitality Health CO-OP is sponsored by the Culinary Health Fund, its national parent Unite HERE Health, and the Health Services Coalition. Hospitality Health CO-OP will operate for everyone in the Exchanges and the individual and small group markets. Hospitality Health CO-OP plans to provide health insurance coverage statewide.

Freelancers CO-OP of New Jersey

Service Area: New Jersey

Award Amount: \$107,213,300

Award Date: February 21, 2012

Freelancers CO-OP of New Jersey is sponsored by Freelancers Union, an association of independent workers that is partnering with providers with an innovative and effective Patient-Centered Medical Home model. Freelancers CO-OP of New Jersey will provide health insurance coverage statewide.

New Mexico Health Connections

Service Area: New Mexico

Award Amount: \$70,364,500

Award Date: February 21, 2012

New Mexico Health Connections is sponsored by a coalition of community groups, business leaders, and providers that plan to work with their provider community to improve health outcomes in 11 counties and expand statewide within two years.

Freelancers Health Service Corporation

Service Area: New York

Award Amount: \$174,445,000

Award Date: February 21, 2012

Freelancers Health Service Corporation is sponsored by Freelancers Union, an association of independent workers whose model is driven by a focus on providing high quality, consumer oriented coverage and financial sustainability that emphasizes the use of patient-centered medical homes. Freelancers Health Service Corporation will provide health insurance coverage throughout New York State.

Freelancers CO-OP of Oregon

Service Area: Oregon

Award Amount: \$59,487,500

Award Date: February 21, 2012

Freelancers CO-OP of Oregon, sponsored by Freelancers Union, is partnering with providers that have an extensive integrated primary care model that will be a strong asset to this CO-OP. Freelancers CO-OP of Oregon will provide health insurance coverage statewide

Oregon's Health CO-OP (Incorporated as Community Care of Oregon)

Service Area: Oregon

Award Amount: \$56,656,900

Award Date: March 23, 2012

Oregon's Health CO-OP (Incorporated as Community Care of Oregon) is sponsored by CareOregon, a non-profit Medicaid Managed Care Organization. Oregon's Health CO-OP will apply its CO-OP loans to participate in the state's new Health Insurance Exchange marketplace. They plan to provide coverage statewide.

Consumers' Choice Health Insurance Company (CCHIC)

Service Area: South Carolina

Award Amount: \$87,578,208

Award Date: March 27, 2012

Consumers' Choice Health Insurance Company is sponsored by a dedicated team of volunteers from not-for-profit organizations, member-driven employer groups and business advocates with expertise in the South Carolina health care and insurance markets.

Community Health Alliance Mutual Insurance Company

Service Area: Tennessee

Award Amount: \$73,306,700

Award Date: August 31, 2012

Community Health Alliance Mutual Insurance Company (CHA) is sponsored by Healthcare 21 Business Coalition (HC21), a member of the National Business Coalition on Health, and LBMC Employment Partners (LBMS), a professional services organization providing financial, accounting services, and Professional Employer Organization (PEO) services to small employers in Tennessee. CHA's mission is to create new health insurance options expected to meet the medical, wellness, and financial needs of insurance consumers in Tennessee. CHA is planning on offering its insurance plans state-wide.

Aarches Community Health Care (AHC or Aarches)

Service Area: Utah

Award Amount: \$85,400,303
Award Date: July 13, 2012

Aarches Community Health Care (AHC or Aarches) is supported by the Association of Utah Community Health, the Salt Lake City Chamber, and the Utah Health Policy Project. This CO-OP will participate in the individual and small group market Exchanges with the mission of transforming the nature of insurance payments and benefits to promote high-quality, patient-centered, integrated, and value-based care in Utah.

The Vermont Health CO-OP (Incorporated as the Consumer Health Coalition of Vermont)
Service Area: Vermont

Award Amount: \$33,837,800
Award Date: June 22, 2012

The Vermont Health CO-OP (incorporated as the Consumer Health Coalition of Vermont) was founded by Vermonters with extensive experience in health insurance and regulation, State health reform efforts, health care delivery, and successful corporate start-ups, with the support of providers, employers, and consumers. The CO-OP will work with Vermont Managed Care, the network affiliated with Vermont's academic medical center, to coordinate the delivery of health services statewide through its growing network of hospitals, physicians, primary care medical homes and other health care providers.

Common Ground Healthcare Cooperative

Service Area: Wisconsin
Award Amount: \$56,416,600
Award Date: February 21, 2012

Common Ground Healthcare Cooperative is sponsored by Common Ground, a community organization in Wisconsin that represents almost 100 small businesses, churches, unions, colleges, and community groups. Beginning its operations in southeastern Wisconsin, Common Ground Healthcare Cooperative will provide health insurance coverage throughout Wisconsin within five years.

Posted on: February 21, 2012

Last updated: October 12, 2012

PLAN MANAGEMENT DRAFT IMPLEMENTATION PLAN

4.1 Appropriate Authority to Perform and Oversee Certification of QHPs

- Governor Steve Beshear issued Executive Order 2012-587 on July 17, 2012, establishing the Kentucky Health Benefit Exchange (KHBE), and giving the following authority related to QHPs:
 - Paragraph IX of the Executive Order states “The Office shall, at a minimum, carry out the functions and responsibilities required under § 1311 of the Affordable Care Act to implement and comply with federal regulations issued under § 1321(a) of the Affordable Care Act, including the submittal of an application for approval of Exchange certification.”
 - §1311(e) of the ACA grants an Exchange the authority to certify QHPs.

4.2 QHP Certification Process

- As part of the collaborative agreement between Kentucky Department of Insurance (KDOI) and the Exchange, KDOI will establish, through administrative regulations, a review process for QHPs to assist in the certification of QHPs in advance of the annual open enrollment period which will include:
 - Application;
 - Insurer rate and benefit information;
 - Transparency data;
 - Accreditation data;
 - Marketing standards; and
 - Network adequacy.

4.3 Plan Management System(s) or Processes that Support the Collection of QHP Issuer and Plan Data

- Based on the number of plans currently operating in Kentucky, we estimate that 5 plans may eventually participate in the Exchange.
- Data systems that will be used to support the operations of Plan Management include:
 - National Association of Insurance Commissioners’ System for Electronic Rate and Form Filing (SERFF)
 - Federal HUB
 - State Data HUB
 - Insurer Systems
 - Benchmark Plan has been selected and awaiting approval

4.4 Ensure Ongoing QHP Compliance

- KHBE will work with existing state agencies to develop a process to track and resolve enrollee complaints.

- Will promulgate administrative regulations as necessary.
- As part of its compliance monitoring program, the Exchange will collaborate with the KDOI to ensure that QHP issuers comply with policies and laws associated with:
 - Plan certification, recertification, and decertification;
 - State insurance market requirements;
 - State network adequacy standards;
 - Rate increase approval and justification process;
 - Enrollee complaint resolution;
 - Plan quality; and
 - Collection of race, ethnicity, language, interpreter use, and cultural competency.

4.5 Support Issuers and Provide Technical Assistance

- Kentucky intends to collaborate with the System for Electronic Rate and Form Filing (SERFF) for training and supporting issuers in the technical aspects of submitting QHP filings.
- Kentucky's Department of Insurance will provide technical support and assistance to issuers for issues outside the scope of SERFF.
- Relative roles of KDOI and CHFS are under discussion.

4.6 Issuer Recertification, Decertification and Appeals

- The KHBE will use its authority to decertify a QHP that is no longer meeting Exchange standards.
- The KHBE will comply with the requirements of 45 CFR 155.1000 and any state standards including KRS 304.17A.
- Issuers will have the opportunity to appeal Exchange decertification decisions. For any issuers or qualified plans that are decertified, a special enrollment period would then be offered to enrollees to select new plans.
- The Exchange is working to establish a process for the QHP issuer appeal of a decertification of a QHP in accordance with 45 CFR §155.1080 and any necessary appeal of QHP certification determinations consistent with any applicable laws or regulations of the Commonwealth.
- The Exchange will provide notice of decertification to:
 - QHP issuer
 - Enrollees in the QHP who must receive information about a special enrollment period
 - Department of Health and Human Services (HHS)
 - Kentucky Department of Insurance
- The Exchange is working with the KDOI to develop its recertification policy for issuers and qualified health plans.
- The KDOI will collect information annually regarding rates, covered benefits and cost sharing requirements pursuant to 45 CFR §155.1020(c) in the form and manner to be specified by HHS.
- The Exchange will complete the QHP recertification process on or before September 15 of the applicable calendar year.

- Upon determining the recertification status of a QHP, the Exchange will notify the QHP issuer.

4.7 Timeline for QHP Accreditation

- The Exchange will review accreditation annually for issuers.
- Beginning in 2013, issuer's accreditation status will be reviewed for the upcoming benefit year.
- For non-accredited plans, the Exchange will establish an accreditation time line by administrative regulation in accordance with 45 CFR §155.1045.
- In the accreditation review that will be performed in 2014 for the 2015 benefit plan year, all issuers will be required to have accreditation by one of the authorized entities.
- If accreditation is not obtained or substantial progress toward accreditation cannot be demonstrated in 2014, the Exchange may opt to decertify plans offered by that issuer.
- A special enrollment period would then be offered to enrollees of decertified plans.

4.8 QHP Quality Reporting

- The KHBE will ensure that QHP issuers meet the minimum certification requirements pertaining to quality reporting and provision of relevant information to the Exchange and HHS by:
 - Collaborating with issuers to ensure that business operations and technical interfaces are developed to support quality reporting and provision of other relevant information;
 - Collaborating with the Kentucky Department of Insurance to review and certify QHPs in accordance with requirements of the ACA, Kentucky Insurance Code, and 45 CFR 155.200 through 45 CFR 155.520, and provide quality reports and other relevant information;
 - Promulgating an administrative regulation which clearly establishes requirements for QHP certification, including detailed requirements for collection of quality information and provision of other relevant information to the KHBE and HHS, consistent with the requirements of 45 CFR 155.200 through 155.520;
 - Providing an insurer portal for the KBHE collection of quality information and other relevant information from issuers which may not be collected through the KDOI, NCQA, URAC or SERFF;
 - Using SERFF to collect accreditation information, quality reports and other relevant information, including but not limited to many of the certificate requirements such as required disclosures, rates, and policy documents. These documents will be reviewed by the KDOI before being forwarded to the KHBE; and
 - Using the NCQA and URAC, as applicable and necessary, to acquire additional quality reports and provide other relevant information, if unavailable through the KDOI, issuers, or SERFF.