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Charting the Road to Coverage

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A Strategic Approach for Insurance Exchanges to Select and Manage Qualified Health Plans

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Introduction and Executive Summary

Contracting with issuers to offer qualified health plans (QHPs) is one of the most important opportunities that Exchanges have to affect health care reform in their states. Initial certification is not the end of the process, but it will help set the tone and brand for each state's health insurance "store." Unlike many start-up tasks, certifying, re-certifying, de-certifying and managing the relationship over time with health plans is an ongoing and evolving set of tasks. Therefore, Exchanges should take a strategic approach to these functions—rather than view them as a set of boxes to check off, each state can craft plan selection and ongoing partnerships to support the achievement of its goals for health care reform.

Before setting specifications for its qualified health plans, and formally soliciting issuer participation, each Exchange must make some key design decisions. Some of these decisions can be made to accommodate issuers' preferences or made by default, but clearly articulating the state's approach to key design questions will help carriers respond appropriately and facilitate the QHP selection and contracting process. For example, communicating in advance with carriers and other stakeholders about procurement goals and corresponding plan specifications allows issuers to provide critical input to their development and to better understand the rationale and expectations behind QHP requirements. Similarly, working out methods for allocating group premiums (if composite rated) among the different participating issuers provides critical information for issuers to develop their premium rate filings.

Section I of this policy brief describes many of the types of decisions that Exchanges should consider in preparing to launch a clean, effective QHP solicitation process. These include:

- Basic Exchange goals that will shape the procurement;
- Key design elements for both the Individual and Small Business Health Options Program (SHOP) Exchanges that directly affect issuers; and
- Some options for communicating in advance with carriers about issues of special interest to them and on which their technical expertise is needed.

Section II describes the standards that Exchanges will use to certify QHPs. It summarizes the major federal requirements that all QHPs must meet and sets forth examples of additional requirements that some states are considering.

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Section III sets forth options for "negotiating" key elements of the issuers' proposals. Three areas for negotiation are singled out in particular:

- Premium rates;
- Marketing efforts; and
- Service level guarantees from carriers.

Exchanges should be prepared for issuers to raise a host of issues for negotiation as well. Some Exchanges have requested letters of interest in advance of requesting full applications in order to predict the level of participation, but even after applications have been submitted, it would be a mistake for states to assume that carriers are fully committed to participating. Some may be inclined by mission to participate, but for all potential issuers the Exchange is a marketing and sales channel. They will make business decisions about their participation and level of commitment based on negotiated terms, operating challenges and evolving business interests. Therefore, it is vital that Exchanges identify which health plans are critical to their mission and business plans, and that Exchanges understand as much as possible in advance of formal RFPs and negotiations about the needs, interests and wishes of these potential issuers.

I. Setting Goals and Aligning Specifications

In preparation for the solicitation of QHPs, states should prioritize their objectives for QHP selection, determine key Exchange design issues that directly impact the kinds of QHPs to be offered to individuals and small employers, and consult with issuers in an effort to understand their needs and preferences and to incorporate their technical concerns.

SETTING GOALS: Because an Exchange markets and sells QHPs, their selection and management will largely define the Exchange. To maximize the benefits offered, each Exchange should first prioritize its objectives in QHP selection and ensure that they align with the Exchange's broader goals, especially its goals for the first few years of operation. By way of illustration, here are some objectives for QHP solicitation and management that support particular Exchange goals:

- **Maximize Carrier Participation in 2014.** For Exchanges that anticipate (or have already received) a weak response from carriers regarding participation, the strategic priority might be to make it as easy and comfortable as possible for issuers to participate, so the Exchange can develop a critical mass of insurance products. For example, the Exchange may want to delay requirements for an issuer to become accredited for as long as possible; allow issuers to offer whatever plan designs they prefer on each actuarial value (AV) tier; and allow new entrants into the state's market to begin participation in the Exchange off-cycle.
- **Maximize Total Volume of Enrollment through the Exchange.** An important initial objective might be to maximize total enrollment, which will attract more carriers, give the Exchange leverage over time, and reduce per-enrollee administrative costs. Pursuing this objective may require that issuers offer their most popular small-group products on the Exchange; that the Exchange allow small employers to pick just one QHP for their employees; and that the Exchange and participating issuers each dedicate significant marketing resources to outreach and enrollment.
- **Maximize Enrollment of Lower-Income, Uninsured Households.** Reaching this objective will require special marketing and outreach efforts to educate consumers and facilitate their enrollment. Encouraging the participation of Medicaid Managed Care Organizations (MCOs) and requiring a substantial marketing commitment from issuers can be especially important to achieve this goal.
- **Achieve Exceptional Customer Service.** An Exchange may want to put early emphasis on designing a website and customer support services that surpass consumer expectations. In this case, the Exchange will prioritize selecting and managing the ongoing relationships with issuers to smooth inter-operability and integration of customer service functions.
- **Minimize Premiums, Especially in the Exchange.** The public expects Exchanges to hold down premiums and yet health reform will lead to "rate shock" for certain populations in some states. A reduction of the cost of health insurance premiums in plans offered through the Exchange would be a major accomplishment and have a positive impact on political and consumer support of the Exchange. If this goal is identified as a priority by the Exchange, the state may need to encourage participation by Medicaid MCOs and signal providers that it expects issuers on the Exchange to pay less than commercial rates for Exchange-specific, non-group products.
- **Become Financially Self-Sustaining by 2015.** This federal requirement can be met with a variety of revenue models, such as Exchange user fees deducted from premiums, a premium tax on all QHPs sold in or out of the Exchange, a premium tax on all non-group and small-group plans, a premium tax on all health insurance policies in the state, general revenues, or combinations of these and/or other sources. Different sources will affect carriers' interest in participation, premium levels in various markets, the certainty of revenues for any given year, and political and popular perception of the Exchange. Because a user fee for QHPs represents a cost to issuers that must be spread across all their non-group and small-group plans, this approach and the level of the fee will influence their interest in participating. In any event, issuers will need to know the method and level of the assessment in order to price for 2014.

- **Promote Payment and Delivery System Reform.** Encouraging patient-centered medical homes and using bundled or global payments to encourage care coordination are high priorities for some states. The Exchange may want to work in tandem with Medicaid, its state employee plans, and even private employer coalitions to promote such reforms by incorporating them into plan selection and/or quality improvement standards across different purchasing entities. As a way to hedge their risk and control costs, issuers may be looking to share risk with providers, and reinforcement of this objective by incorporating payment reform into QHP selection criteria can assist issuers in negotiating such arrangements with providers.

SETTING QHP SPECIFICATIONS IN ALIGNMENT WITH EXCHANGE GOALS

Non-Group (Individual) Market Products: *As a threshold matter, the Exchange must decide if it wants to institute any QHP selection criteria beyond the federal minimum standards (set forth below). If additional criteria are desired, some of the key decisions that will dictate issuers' proposals include the following:*

- **Types of Plans to be Solicited.** In deciding whether to focus its recruitment efforts on HMO, PPO, POS or High Deductible Health Plans (HDHP) plans—or to allow insurers to decide which types of plans to offer—an Exchange should consider which plans are most popular and most cost-effective. When offered side-by-side, open-panel plans tend to attract worse risk than closed-panel plans, so Exchanges should take risk selection into account as well in developing plan specifications.

- **Standardization of Cost-Sharing Features across QHPs.** Issuers generally oppose standardizing cost-sharing designs across QHPs, despite considerable evidence that some degree of standardization improves the consumer's ability to compare and make rational selections among health plans. On the other hand, standardization of cost-sharing designs can discourage innovation. Some Exchanges have decided on a middle ground, by requiring each issuer to sponsor at least one standard plan at each designated AV level, but allowing them discretion to offer additional non-standard plan designs. (Presumably, their websites will give consumers the choice to view and compare all, or subsets of, QHPs, including only the standard QHPs on each AV level.)

- **Number of QHPs from Each Issuer per Actuarial Value Level.** Federal regulations require each issuer to offer one plan at the silver level and one at the gold level. Each Exchange must decide whether to allow plans to offer additional plans and, if so, how many and what criteria such additional plans must meet. This decision requires balancing the risk of consumer confusion if too many plans are available against the desire for a wide range of choices and robust carrier participation.

- **In-Network Coverage of Out-of-State Services.** The Exchange should consider whether to build this feature into its requirements for QHPs, at least for plans that have an out-of-state provider network. Generally, out-of-area coverage is attractive to consumers, but can add expense.

Small Group Market (SHOP) Products: *An Exchange must also establish its QHP design and employee choice model for SHOP products. Some of the most important considerations in setting these Exchange features are:*

- **Value Proposition of SHOP for Small Employers.** Unlike the generous federal subsidies available exclusively through Exchanges to lower-income individuals, tax credits for small employers may not suffice to attract very many customers. To attract small employers, the Exchange needs to develop and promote a compelling value proposition. In a few markets, such as California and Utah, offering employees a choice that includes an integrated delivery system (Kaiser and InterMountain, respectively) may suffice. Alternatively, if an Exchange can offer less expensive coverage than is available outside the Exchange by, for example, recruiting and promoting Medicaid MCOs, it may be able to attract small employers. A third approach is to promote defined contribution, which works best if employees are given a full menu of meaningfully differentiated plans and premiums from which to choose. (See Employee Choice below.)

- **Specification of QHPs Offered in SHOP.** An Exchange might ask issuers to offer the same plans on the SHOP Exchange as it offers to individuals on the Exchange, in order to promote portability of coverage. Or, to promote the appeal of SHOP, the Exchange might ask issuers to offer all the same products to small groups in and out of the Exchange, or a subset consisting of their most popular small-group plans. (Because so many plan designs will have to change for 2014, selecting the most popular ones may be more challenging for 2014 than for later years.)

- **Employee Choice Model(s).** By Centers for Medicare and Medicaid Services (CMS) regulation, the range of choices available to employers and their employees must include all QHPs on an AV level, but can extend to the full menu of all QHPs on the SHOP Exchange, or options in between. Full menu comports especially well with a defined contribution approach, and survey results reveal that it is heavily favored by employers and employees.[1] However, it creates premium-increasing adverse selection and is often opposed by carriers. Carriers are generally resigned to the federally required choice of all QHPs on a single AV level, and if more choice is to be offered they seem to favor offering multiple QHPs from a single carrier. The employee choice models offered on SHOP will affect the response of carriers to a Request for Application (RFA) or Request for Proposal (RFP), as well as the value proposition and differentiation of SHOP from the outside market.

- **Rating Structure (Composite or Individual).** In states where list billing is common, individual rating works better than composite rating with employee choice of different issuers. Because composite (or average) rates for a group do not vary with the age and other rating characteristics of individuals selecting different QHPs in SHOP, a technical "fix" must be developed to protect issuers from adverse selection. This is a substantial concern to issuers and should be addressed with the potential issuers prior to asking them to commit to participate in SHOP.

COMMUNICATING WITH CARRIERS: Meeting with carriers to solicit concerns, feedback and their interest in participation is vital to establishing a successful Exchange. Carriers will be keenly interested in the Exchange's design and policies. They will take these into consideration when deciding whether and how to participate on the Exchange, and will commit resources to supporting or competing with the Exchange. Conversely, their QHPs and their operational support for the Exchange will be critical in shaping its character and influencing its success. The negotiating process really begins at this point, and much of the give-and-take may actually precede developing a formal request for proposals. (See Section III on negotiations, below.)

Exchanges will want to consult with potential issuers on three levels, in overlapping sequence:

- General stakeholder consultation, early in the process, to explain health reform, Exchanges and policy decisions, and to solicit broad input to policy decisions;
- Direct consultation on key Exchange design issues that directly affect issuers, including many of those described above; and
- Technical working group(s) to address rating issues, broker commissions, specifications for information flows and reporting, joint marketing, etc.

After contracting with issuers is complete, the Exchange should establish ongoing communications and problem resolution processes with each issuer, and the contract should require issuers to identify and commit time from the appropriate (skills and seniority) contacts at each issuer.

II. Setting Requirements for Proposals

In soliciting proposals, the Exchange should set forth its requirements for QHPs, including both the minimum federal standards plus any incremental requirements that the Exchange has decided to add. The Exchange should also determine and clearly articulate to issuers the process that it intends to follow to negotiate acceptable proposals.

FEDERAL REQUIREMENTS FOR QHPs: Regulations issued pursuant to the Affordable Care Act establish minimum requirements for QHPs.[2] A brief summary of the most significant federal requirements follows:

- **Accreditation.** Each QHP offered on an Exchange must be accredited based upon its local activities (i.e., national product accreditation is not allowed). HHS has thus far approved only the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) as accrediting organizations. If plans are not accredited at the time of initial offering, the Exchange must define the time frame allowed for accreditation. CMS is giving Exchanges substantial leeway to defer formal accreditation in the early years.
- **Offering Requirements.** Each issuer must offer at least one QHP at the silver coverage level and at least one at the gold level. Each issuer must also offer a child-only plan (individuals <age 21) at the same level of coverage as any QHP it offers through the Exchange.
- **Quality Initiatives.** QHPs must feature a health care quality improvement strategy that includes reporting on progress against quality metrics. The outcomes must be reported to U.S. Department of Health and Human Services (HHS) annually. Issuers must also implement a consumer satisfaction survey protocol to be developed by HHS.
- **Network Adequacy and Provider Directory.** Each QHP must meet certain network adequacy requirements and must maintain a provider directory that indicates which providers are accepting new patients. Each QHP must include Essential Community Providers within its provider network.
- **Transparency in Coverage.** Issuers must institute transparent reporting on a range of matters, including claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, etc. to the Exchange, HHS, the state insurance commissioner and the public. Exchanges must also develop cost-sharing calculators on their websites so that enrollees can estimate the amount of cost-sharing (including deductibles, copayments and coinsurance) under each QHP.
- **Segregation of Funds for Abortion.** Each QHP must segregate abortion funding for purposes of Advance Premium Tax Credits (APTC) administration.
- **Minimum Service Area.** Federal requirements mandate that a QHP's service area must encompass at least one county; however, an Exchange may designate a smaller or larger geographic service area as the minimum service area. Service areas must be established without regard to racial, ethnic, language, health status-related factors that operate to exclude certain populations.
- **Rate and Benefit Information.** Issuers must set QHP rates for an entire benefit (calendar) year or, for SHOP, for the entire plan year. Issuers must submit rate and benefit information to the Exchange. Prior to implementing a rate increase, an issuer must submit justifications to the Exchange and must prominently post its justification on the issuer's website.
- **Non-Discrimination.** QHP issuers may not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation. Non-discrimination standards apply to benefits design, marketing, outreach and enrollment, and all other relevant functions.

- **Licensure and Good Standing.** Each issuer must be licensed and in good standing in the state.
- **User Fee Compliance.** Issuers must comply with health benefit Exchange funding mechanisms, which Exchanges must design so as to be self-sufficient by 2015.
- **Risk Adjustment Programs.** Issuers must comply with risk adjustment programs established for individual and small group markets.
- **Enrollment Policies and Procedures.** Issuers must accept a QHP selection from an applicant who is determined to be eligible for enrollment in accordance with federal and state standards. Federal regulations set out standards for both individual and SHOP initial open enrollment, annual open enrollment, special enrollment periods, enrollee notification, premium payments, grace periods, enrollment termination, and enrollment reconciliation.

ADDITIONAL REQUIREMENTS FOR CERTIFIABLE QHPs: Each Exchange may supplement the federal minimum requirements for QHPs with additional specifications that promote particular objectives. Exchanges may want to consider features such as the following:

- **Integration of Medicaid MCOs and/or Smoothing Transitions between QHPs and Medicaid MCOs.** Lower income individuals, especially those near the minimum eligibility for APTCs (100 percent to 138 percent of Federal Poverty Level [FPL], depending on the state's cut-off for Medicaid) may "churn" in and out of the Exchange, as their income and eligibility fluctuate. An Exchange may want to try to smooth the resulting disruption in these individuals' coverage by requiring Medicaid MCOs to offer roughly equivalent products on and off the Exchange, that feature continuity of coverage mechanisms to allow individuals to easily switch between them. Provision should also be made for continuing drug coverage and case management services during the transition between policies for individuals who are receiving care for a chronic condition or pregnancy.
- **Network Adequacy Standards in Excess of Federal Requirements.** An Exchange may want to implement higher standards for provider networks than those required by federal standards. One area to which some states have given special attention is access to Essential Community Providers.
- **Cooperative Efforts to Transition Non-Group, Subsidy-Eligible Enrollees in the Exchange.** In states with a large non-group market, implementation of the Exchange could hurt existing carriers if their low-income enrollees abandon them for subsidized offerings available through the Exchange. On the other hand, efforts by carriers to hold onto some of their members outside the Exchange could run contrary to the best interests of their members and the mission of the Exchange. The carrier and the Exchange may each benefit from cooperatively developing a mechanism by which the carrier transitions current enrollees who are subsidy-eligible into an equivalent product within the Exchange. This would protect the insurer's interests while helping individual enrollees to take advantage of subsidies. A requirement for issuers to participate in jointly developed marketing plans aimed at incumbent members could be an important part of the QHP solicitation.
- **Link Issuers' Participation in Individual (Non-Group) and SHOP (Small Group) Exchanges.** Some carriers may be interested in developing QHPs only for the non-group market because of the perception that federal subsidies for individuals will drive substantial enrollment in this area. Conversely, states which regulate premiums in the non-group market may have trouble attracting carriers to that segment. States that are concerned about a lack of carrier participation in one or the other market should at least consider requiring issuers that propose non-group QHPs to also participate in SHOP, or vice versa.

SOLICITATION PROCESS: Before an Exchange releases its RFP/RFA to carriers, it should inform issuers about the following process steps:

- **Process and Timeline for Certifying QHPs.** Carriers must understand the certification process before they submit products for rate review. The Exchange must work with state agencies, such as the Department of Insurance (DOI) and perhaps the state Medicaid agency, to coordinate the various tasks involved in certification and to develop a timeline for decisions.
- **Confidential Information of Applications.** Exchanges should determine how state regulations on procurement and Freedom of Information requests will apply to the QHP certification process. A process should be developed to allow carriers to protect proprietary information or trade secrets from public disclosure.
- **Development and Release of the Model Contract.** Developing a model contract with carrier input can begin even before the formal solicitation of proposals. Early release of a model contract for carrier review and comment, and informal negotiations at this point should enhance the Exchange's negotiating leverage after the RFP is released. The Exchange should have a good sense prior to certifying a particular QHP whether or not the issuer is willing to accept the Exchange's preferred contract, and which proposed terms are most problematic for issuers. Whether or not informal contract negotiations precede this step, releasing a proposed model agreement with the RFP/RFA will reduce issuers' uncertainty—if not anxiety—and speed negotiations once the Exchange selects QHP proposals to certify.
- **Term of Certification, Re-Certification and Next Application Cycle.** Some state Exchanges desire to certify QHPs for more than one year in an effort to encourage carriers to participate early, rather than sit out the first year, watch how the Exchange performs, and then decide whether to participate or market against the Exchange. However, the Exchange should also consider how it can encourage new plans to join after initial certification.

- **Opportunities and Process for Exchange and/or Issuers to Modify QHP Designs over Time.** Each Exchange will have to determine whether it or the carriers will be able to modify plan features or rates after certification has been granted. If no modification is allowed, innovations and improvements in coverage may be stymied. However, allowing modifications can also encourage gamesmanship. If an Exchange decides to allow modifications, it must carefully design a governing process.

- **Publication of a Draft RFP/RFA for Carrier Comment.** Release of a proposed RFP/RFA for carrier comment can encourage carrier buy-in and help identify problem areas early in the QHP certification process. A window of time should be designated for the carriers to submit written questions or comments, which the Exchange can post on a discussion board or other open forum, along with its responses. Such a transparent discussion among the Exchange and all carriers can strengthen all stakeholders' confidence in the process.

- **Data for Carriers.** An Exchange may wish to furnish data to issuers that may be used by them to develop pricing and other elements of their proposals. The more information an Exchange can furnish on its target markets, outreach and marketing resources, risk adjustment approach, etc., the less uncertainty carriers will have to factor into their pricing for their non-group and small-group products.

- **Articulation of Selection Criteria and Process.** The Exchange should publish a clear statement of its QHP selection criteria, as well as how the selection process will be conducted. It should try, to the extent known, to delineate non-negotiable criteria as well as what facets of the plans will be open to subsequent negotiation.

- **Operational Requirements and Obligations.** An Exchange should also articulate its operational requirements of QHPs. For example, will submissions of rating disks be required on a monthly basis or will the Exchange require some other form of updating premium rates? Certain operating decisions, such as whether the Exchange will perform non-group premium billing, will impact issuers in planning their business model for Exchange participation. While not all operating decisions can be made prior to requesting issuers' proposals, this aspect of the Exchange/issuer relationship should not be neglected. It is a crucial component of certification and contract development.

III. Negotiating Terms with Carriers

To achieve acceptable proposals, the Exchange may employ one or more of several methods for influencing premium rates, as well as some combination of specifying and negotiating other contract terms.

The negotiating process should actually start in an informal way prior to issuing a request for proposals. Depending on state procurement regulations and the insurance department's rate review process, key elements of the solicitation cannot be discussed with issuers, let alone negotiated, after the solicitation is released and prior to the certification of QHPs.

PREMIUM RATES: States may simply accept proposed rates, or they may try to influence them through one or more of the following steps:

- **Defer to State Rate Review Process.** The Exchange may exclude rate review from its certification process by delegating this task to the state department of insurance, and simply accept reviewed rates.

- **Establish Actuarially Sound and Competitive Trend Factors.** The Exchange should ask issuers to justify their proposed rates based on historical costs, updated for medical inflation and other cost trend factors (e.g., changes in risk pool, additional covered services, and taxes due to ACA). If the state's insurance department is not performing this function rigorously across the entire market, the Exchange can try to negotiate reasonable trend factors with individual issuers, based on outside actuarial advice and market standards (competitors' rating information). However, rates in and out of the Exchange will be affected by any such change—unless the issuer participates in the relevant market segments only through the Exchange—so the Exchange may have relatively little negotiating leverage on broader market premiums.

- **Select Lower-priced Proposals.** The Exchange may adopt a policy of approving lower-priced proposals, provided that they meet all the other certification requirements of the Exchange. This policy should encourage more robust rate competition among competing issuers.

- **Re-bidding.** If proposed rates are unacceptably high, the Exchange may want to have a contingency plan in place that allows it to work with carriers to identify the factors that are responsible for unacceptably high premiums, attempt to ameliorate these factors, and then require the issuers to re-bid.

JOINT MARKETING INITIATIVES: The success of health care reform in reaching the uninsured will depend in part on the Exchange's outreach and marketing efforts. Moreover, the larger and more successful its marketing effort, the more negotiating leverage the Exchange should enjoy vis-à-vis issuers. The Exchange may want to supplement its own outreach efforts by asking participating issuers to commit resources to joint marketing efforts. Issuers also have considerable experience promoting coverage, so it makes sense for the Exchange to work together with issuers from an early stage to design joint outreach and marketing plans. Procurement rules may preclude joint planning efforts before proposals have been made, but most Exchanges can require potential issuers to commit marketing resources as part of their proposals, and to develop joint marketing efforts with the Exchange prior to certification. In effect, the Exchange and carrier will negotiate the level of resource commitment while jointly planning activities as part of the certification negotiations. Joint marketing efforts should distinguish among and may include all or some of the following target segments:

- Existing enrollees who may qualify for subsidies through the Exchange;
- Twenty-five year olds aging out of dependent coverage;
- COBRA-eligible enrollees, especially those who may qualify for subsidies through the Exchange; and
- The uninsured, especially those who may qualify for subsidies through the Exchange and small employers, especially those who do not currently offer group coverage.

SERVICE LEVEL AGREEMENTS: Achieving good customer service and operating efficiency will require close working relationships between the Exchange and participating issuers. The contract with issuers should include a list of issuers' obligations and performance expectations or service level agreements. These will need to be negotiated with issuers, and may vary from one issuer to another, depending on a realistic assessment of their varying capabilities. At a minimum, service level agreements should address customer call center interactions and transfers, premium billing and collection protocols, sales and marketing efforts, reporting requirements, and assigning lead accountability at each issuer for major functions that require close coordination between the issuer and the Exchange. Here are some examples of issuer obligations and performance expectations (not a comprehensive list):

- The issuer must employ a qualified individual to serve as the Exchange's primary point-of-contact. Such person must be authorized and empowered to represent the issuer regarding all matters pertaining to the contract between issuer and Exchange.
- The issuer must work collaboratively with the Exchange to identify opportunities to reduce health care disparities for members through improved data collection on race, language and ethnicity.
- The issuer must have administrative and management arrangements or procedures, including a mandatory compliance plan, which is designed to guard against fraud, waste and abuse.
- The issuer must maintain a continuity of operations plan that addresses how issuer operations will be maintained in the event of a natural disaster, terrorist attack, pandemic or other event which leads to a significant disruption in operations due to staff absence and/or loss of utilities. The issuer must share copies of such plan with the Exchange upon request, and must inform the Exchange whenever such plan is implemented.
- The issuer must monitor and enforce access and other network standards required by statute or regulation and take appropriate action with providers whose performance is determined by the issuer to be out of compliance. The issuer must operate a toll-free member services telephone line a minimum of eight hours per day during normal business hours, Monday through Friday, which must:
  - Have at least "X" percent of the calls answered by a trained member services department representative (non-recorded voice) within thirty (30) seconds or less; Have less than a "Y" percent abandoned call rate;
  - Make oral interpretation services available in all non-English languages spoken by members; and
  - Maintain the availability of services, such as TTY services or comparable services for the deaf and hard of hearing.

CONCLUSION

The initial criteria and process for certifying QHPs will largely define the character of an Exchange, at least in its early years of operation. By identifying its strategic goals and consciously structuring its QHP certification and contracting process to promote those goals, an Exchange can influence the character of the state's non-group and small-group insurance marketplace. Of course, the carriers and the Exchange each need the other to make reform work and achieve their other objectives, so each market and set of interactions with health plans will present unique opportunities and obstacles. Careful planning and consultation with potential issuers, leading to effective partnerships in support of the Exchange's goals, can help create a robust marketplace for health insurance.

[1] "Rhode Island Exchange: 2011 Qualitative Research," RKM Research & Communications (October 11, 2011) unpublished; Vermont Exchange: 2012 Qualitative Research," RKM Research & Communications (May 23, 2012) http://dvha.vermont.gov/administration/employer-health-insurance-preference-research-5-31-12.pdf/view?searchterm=rkm; and New York Exchange: Employer Health Insurance Preference Research," Wakely Consulting Group and RKM Research & Communications (January 2013) unpublished.

[2] 45 C.F.R. §§ 155 and 156 (2012).