Checklist to Choose a Health Plan

Beginning in 2014, the Affordable Care Act (ACA) will create new health insurance exchanges or marketplaces where people who do not have other sources of insurance can purchase an individual or family policy. Plans on the exchange are grouped into metal levels based on their generosity and overall price, but the individual plans can vary widely. It will be important for you to consider a range of factors when purchasing a plan on the exchange to help minimize your overall costs and maximize your access to needed healthcare services. This checklist identifies key questions that can help you make an informed decision when picking a plan.

General Questions

- ☐ Do you and your family members have coverage through a government insurance program—Medicare, Medicaid, CHIP, VA, or TRICARE? If so, you don't necessarily have to make any changes.
- ☐ Do you have access to coverage through an employer? If so, you don't necessarily have to make any changes. Have you already purchased your own coverage? If so, you may be able to keep your plan but you should check whether you may be eligible for subsidies in the exchange

Estimating your Health Needs

- ☐ How many times a year do you visit a doctor? Do you see a primary care doctor, specialists, or both?
- ☐ How many times a year do you visit an urgent care center or emergency room?
- ☐ Have you been hospitalized in the last year? How long is your typical hospital stay?
- ☐ Do you expect to need surgery or another major procedure in the next year?
- ☐ Do you take any prescription medications? Include medications from a pharmacy or that are administered at the doctor's office. Be sure to think about any medications you may have been prescribed but do not currently take because you cannot afford them.
- ☐ Do you have any chronic conditions that could put you at risk of high health costs?

Financial Assistance

- ☐ Do you qualify for a premium subsidy? You may qualify if your annual household income is below 400% of the federal poverty line—that's about $46,000 for an individual and $94,000 for a family of four. You can use a premium subsidy for any plan offered on the exchange.
- ☐ Do you qualify for assistance with the share of health costs that are not coved by insurance? You may qualify if your annual household income is between 100% and 250% of the federal poverty line—that's about $11,500 to $28,700 for an individual and $23,600 to $58,900 for a family of four. In order to receive assistance with your share of health costs, you have to enroll in a silver plan.

Determining the Right Level Plan

- ☐ Do you qualify for Medicaid in your state? Eligibility varies by state, and you will be notified if you qualify during the first step of applying for an exchange plan.
- ☐ Are you in good health with low current healthcare costs? Do you have savings you could use for unanticipated health costs? If so, a bronze or silver plan may work for you.
- ☐ Are your health care needs and costs moderate? Are you concerned about your ability to pay for unexpected medical costs out of pocket? If so, a silver or gold plan may work for you.
- ☐ Do you have a chronic condition or significant health care costs? Are you concerned that you may not be able to pay for unexpected health costs? If so, a gold or platinum plan may work for you.

Checklist to Choose a Health Plan

Covered Benefits and Costs

- ☐ Are the services you and your family need covered by the health plan? Although all plans cover certain key benefits, there will be some variation in the services covered by each exchange plan.
- ☐ What is the plan's deductible? The deductible is the amount you have to pay before a health plan starts to pay for your care. Are there separate deductibles for medical and prescription drug costs?
- ☐ What are you required to pay for physician visits? Is it different for a primary care physician or a specialist? What share of a hospitalization would you be required to pay?
- ☐ Does the plan you are considering limit any services to a number of visits or sessions per year? This may apply to specific types of services, like chiropractic care or physical therapy.

Coverage for Prescription Medications

- ☐ Are the medications you take regularly covered on the plan's formulary? A formulary is the list of medicines covered by a health plan. The exchange website will include a link to the formulary so that you can see the list of covered medications.
- ☐ Formularies typically have several tiers with patients asked to pay more for medicines on higher tiers. Which formulary tiers include your prescriptions? What are the costs you will have to pay for each tier? Will you pay a set amount (a co-pay) or a percent of the medicine's cost (coinsurance)?
- ☐ Are there any steps you or your doctor will need to take before your drugs will be covered? In some cases, plans only cover a medicine once a patient has gone through step therapy, which means the patient has tried other medicines before taking the one the doctor originally prescribed. Insurers also sometimes require that a doctor receive permission from a plan before prescribing a drug through a process known as prior authorization.
- ☐ Is there a separate deductible for prescription medications? If you regularly take prescription(s) but rarely use other health services, you might spend less on health costs if you choose a plan with a lower separate deductible for prescriptions instead of one higher deductible for all costs.
- ☐ Is there a separate out-of-pocket maximum for prescription drugs? If plans tend to require you to pay for a significant percent of the cost of your medicine and you use few other health services, you may pay less overall if you choose a plan with a separate out-of-pocket maximum for prescriptions.
- ☐ What are the options if your provider prescribes a medicine that is not on the plan's formulary?

Access to Providers

- ☐ Are the physicians you see regularly in the plan's network? You should check for all physicians you may see. If you see doctors not in the plan's network, you may be charged more in out-of-pocket costs and that spending may not count toward the limit on your out-of-pocket costs.
- ☐ Is your preferred hospital in the plan's network?
- ☐ Will the plan require a referral to see a specialist or get other services?

The purpose of this tool is to describe some of the factors a patient may wish to use to evaluate health plans. Each person should make an independent decision about his/her selection of a plan based on individual circumstances and adequacy of coverage in consultation with trusted advisors. Other information is available through your state's Exchange.

Choosing the Best Plan for You: A Tool for Purchasing Coverage in the Health Insurance Exchange

The Affordable Care Act (ACA) makes health insurance available to nearly all Americans and the law requires people to maintain health coverage beginning in 2014. That coverage can be obtained through a government program (like Medicare or Medicaid), an employer, directly through an insurer, or through a policy purchased on a state health insurance exchange (also known as a health insurance marketplace) where you can buy an individual or family policy.

This tool guides you through the characteristics of health plans offered on the exchange (also known as qualified health plans) to help you select the best plan for yourself or for a person you are assisting. The tool is structured as follows:

1. **Overview of Plan Design**. Review of plan benefit design and generosity of various plan options
2. **Financial Assistance in the Exchange Marketplace**. Overview of financial assistance that may help you pay for the cost of a plan
3. **Key Components of Plan Selection**. Guidance through a set of considerations to evaluate available plans

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Overview of Plan Design

New insurance reforms affect all plans

All plans offered on the exchanges will meet certain new guidelines specified by the Affordable Care Act. You cannot be denied coverage because of a pre-existing condition. Plans cannot charge more based on medical history or current health care needs. Health plans must offer a set of preventive services for free, such as immunizations, women's health services, and screening colonoscopies. All plans must cover ten categories of essential health care benefits including doctor's visits, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription medicines, and rehabilitation care.

Bronze, silver, gold and platinum indicate generosity of coverage

To make comparisons easier, plans will fall into one of four levels of coverage—Platinum, Gold, Silver, and Bronze. Each level corresponds to the portion of health care costs that the plan covers, ranging from most generous to least generous. Platinum plans have the highest premiums and lowest out-of-pocket costs, while bronze plans have the lowest premiums and the highest out-of-pocket costs. On average,

platinum plans cover 90% of an average enrollee's health care spending, and the patient covers 10% (plus his or her premiums). On the other end, bronze plans cover 60% of an average enrollees' health care spending, and patients are responsible for the remaining 40%. In between, silver plans cover 70% and gold plans cover 80% of health care costs. If you are under 30 or if the other Exchange options are not affordable to you under the standard in the ACA, you may be eligible to buy a plan that is less expensive than a bronze plan but that provides limited benefits until you have very high health costs.

At first glance, bronze plans may be most appealing because of their low premiums. However, enrollees with regular or chronic health care needs may have to pay significant out-of-pocket costs to fill a prescription, visit the doctor, or obtain care for an unforeseen medical need. In addition, some individuals with low incomes will receive significant additional subsidies if they buy a silver plan; and in some cases they could end up paying significantly more in the long-run if they buy a bronze plan. See *Financial Assistance in the Exchange Marketplace* for details.

The Affordable Care Act also caps the amount you can be asked to spend out-of-pocket each year at $6,350 in total (medical and prescription drug) spending for 2014. In 2014, the maximum is $12,700 for a family. This annual out-of-pocket maximum applies to all exchange plans—bronze through platinum—though many plans will have a lower maximum than $6,350. Out-of-pocket spending that applies toward the cap includes deductibles, copayments, coinsurance, and cost-sharing (but not premiums).

Deciding on a metal level is the first step in understanding which plan may be right for you. You also will want to understand how your plan's benefits are designed so that you strike the balance between coverage that meets your health care needs and the amount you are willing to pay in premiums and out-of-pocket costs. All plans within a single metal level are not the same, and depending on your particular health needs and the prescription medications you take, the amount you pay out-of-pocket each year could vary significantly within the same metal level. See the *Key Components of Plan Selection* section for a guide to choosing among plans in a given level of coverage.

QUICK TIPS

- ◊ All exchange plans cover a set of essential health benefits, and you cannot be denied coverage or charged more because of a pre-existing condition.
- ◊ Metal levels—bronze, silver, gold, and platinum—describe the overall generosity of each health plan. Platinum plans cover the highest percentage of health care costs, 90% on average, but have the highest premiums.
- ◊ Plans at the same metal level and similar premium may have wide variation in out-of-pocket costs, depending on your health needs.

Financial Assistance in the Exchange Marketplace

People who wish to purchase coverage in the exchange will need to provide information on their income. The exchange then will determine whether they qualify for health insurance through Medicaid, for subsidies to help pay the costs of an exchange plan, or for unsubsidized coverage in the exchange.

Tax credits help middle and lower income individuals pay health plan premiums

For lower and moderate-income individuals and families, the federal government will provide assistance to help pay for premiums. Subsidies are determined on a sliding scale based on income. People at the lower end of the income scale get the most help. The subsidy is based on the premium for the second lowest cost silver plan available in the state's exchange; that means the amount of the subsidy is generally fixed, regardless of which plan an individual picks. The individual pays more in a more expensive plan and less in a less expensive plan.

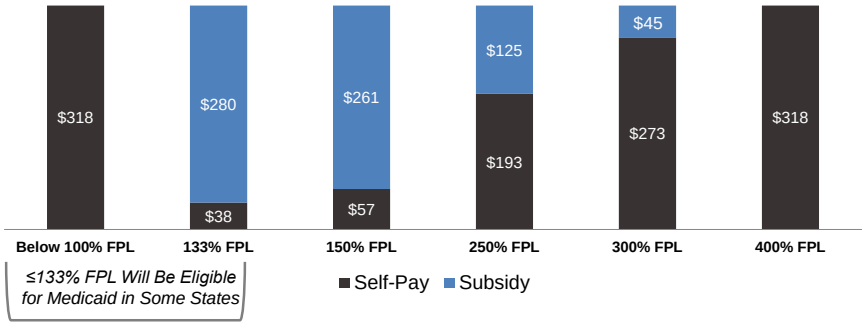
Individuals or families with income between 100 and 133% of the Federal Poverty Level get the most help paying premiums. This group includes individuals with income between about $11,500 and $15,000. For a family of four, these income levels are between about $23,500 and $31,000. If one of these families enrolled in the second-lowest cost silver plan, they would contribute only about 2% of their income toward their premium. For example, an individual making $15,000 a year would pay approximately $25 a month toward his or her premium for the second lowest cost silver plan. The remainder of the premium is paid by the government. These subsidies are not available to individuals who are eligible for Medicaid, Medicare or who have an affordable offer of employer coverage.

On the other end of the income spectrum, individuals and families up to 400% of the Federal Poverty Level also may qualify for premium subsidies. This group includes individuals with income up to about $46,000. For a family of four, this income level is about $94,000. This group will have to contribute about 9.5% of their income to purchase the second lowest cost silver plan. An individual making $45,000 a year would pay approximately $356 a month, or $4,275 a year, for coverage in the second lowest cost silver plan.

Figure 1 offers an example of premium tax credits in California. The subsidies in your state may be different, based on the cost of the second lowest cost silver plan offered on the exchange. Family size, age, and region will also help to determine the subsidy amount for which you qualify. Individuals with incomes below 100% of poverty are typically not eligible for Exchange subsidies. In some states these individuals will be eligible for Medicaid. Legal immigrants who are not eligible for Medicaid may receive a premium subsidy in an Exchange plan, even if their income is below 100% FPL.

Figure 1

Example: Premium Subsidy By Income Level for Blue Shield's Silver Plan (Region 1 in California)



Individuals should also be careful when estimating their income if they apply for premium subsidies. If a person's total yearly income is higher than what the person estimated when he or she applied for premium subsidies, it is possible that the Internal Revenue Service (IRS) may require some of that subsidy to be repaid when the person files his or her taxes. Therefore, individuals may want to factor in expected increases in their income over the course of the year when they apply for coverage. For example, some individuals may work extra hours during the Christmas holiday season or may receive a year-end bonus that could affect the level of subsidy for which they qualify. Individuals who are not sure what their income will be in the future should report their current income, but be sure to tell the exchange when their income changes. Reporting income changes will help ensure people get the subsidies they are entitled to and to reduce the likelihood they have to repay subsidies at the end of the year. Individuals can also choose to take a smaller subsidy than they are entitled to, so they avoid having to repay part of the subsidy. If at the end of the year they are entitled to a larger subsidy than they have received, they will receive that money with their tax rebate.

People with limited income also may qualify for help to reduce the out-of-pocket costs of a plan

The lowest income people who are eligible for premium tax credits also qualify for cost-sharing assistance. This means that the federal government will help pay for out-of-pocket costs such as deductibles, coinsurance, and copays. You will qualify for such assistance if you make between 100% and 250% of the Federal Poverty Level, about $11,500 to $28,700 as an individual, or $23,500 to $59,000 for a family of four.

Cost-sharing assistance lowers the out-of-pocket maximum for people who qualify. Much like premium subsidies, the maximum out-of-pocket cost an individual or family pays is based on income. For those making 100% to 200% of the Federal Poverty Level, the out-of-pocket maximum is reduced by two-thirds from $6,350 to about $2,117 in 2014. For those making 200% to 250% of the Federal Poverty Level, the out-of-pocket maximum is reduced by one-fifth from $6,350 to $5,080 in 2014. For a family, these out-of-pocket maximums are doubled.

People who qualify for cost-sharing reductions will receive notification of their eligibility when they apply for coverage in an Exchange. To gain access to the cost-sharing reductions, eligible individuals and families must enroll in a silver plan that is designed with the appropriate level of reduced cost sharing. The exchange will direct eligible individuals and families to the correct set of plans. When these individuals compare among plans on the exchange website, the cost-sharing levels displayed should reflect the reduced cost-sharing amounts.

QUICK TIPS

- ◊ You may qualify for a subsidy to use toward paying your premium, and some individuals will also get help with out-of-pocket costs. Your state's exchange website or enrollment hotline will verify if you qualify for help when you sign up to purchase coverage.
- ◊ If you qualify for a premium subsidy, you will not have to pay your entire premium cost upfront; the federal government will pay its portion directly to your health plan, and you will be billed for your monthly contribution only.
- ◊ You must purchase the silver plan variation that applies to your income level to access your cost-sharing assistance.

Key Components of Plan Selection

Plan Generosity

Premium costs and the generosity of coverage vary with the metal level of the plan you select. Your state exchange website may have a cost calculator that helps you to estimate your premium and out-of-pocket costs under various plan options. However, calculators may be more widely available after 2015.

If you have a chronic condition, take several prescriptions, or need an expensive medical treatment in the near future, selecting a gold or platinum plan may be a better choice for you. Your cost sharing and total out-of-pocket spending may be lower under such a plan, though premiums may be higher. You will need to balance your need for health care services with the amount you want to pay in premium and out-of-pocket costs.

Individuals who expect less extensive health care needs may prefer to purchase less expensive bronze or silver plans. Importantly, people who receive cost-sharing reductions must enroll in the silver plan variation that applies to their income level to receive the benefit of the cost-sharing reduction.

Once you decide the level of coverage that is right for you, there are other decisions to make. Each state will have several plans at each metal level. The next three sections of this toolkit will help you sort through other factors to consider when enrolling in an Exchange plan—covered benefits and costs, provider networks, and coverage of prescription medications.

Covered Benefits and Costs

It is important to enroll in a plan that covers the health care services you and your family utilize most frequently. Plans are required to cover services across a variety of categories, but the specific kinds of care you need may not be included in the benefits of every health plan, even if you are comparing plans in the same metal level. You will also want to understand the cost-sharing structure under your plan—the deductible, copayments, and coinsurance. Finally, you should identify any limits on covered items or services, such as the number of times you can receive a recurring treatment or whether you need plan authorization before receiving a covered service. You can use the *Checklist to Choose the Best Plan for*

You from this toolkit to help you gather the information you should consider to select the plan that meets your needs.

Exchange websites will display each plan's benefits in a standardized way so that you can compare across your options more easily. The plan also must provide information about the services that are excluded from coverage. If you or your immediate family members have specific health care needs, you should narrow your options to the plans that cover those specific services. If you or your family receives health care items or services that are not covered by the plan, you will have to pay for the entire cost of that care.

In most states, plans within the same metal level will vary in cost-sharing requirements. Exchange websites will include a summary of deductibles, copayments, and coinsurance for different types of covered services. You may have a single deductible for all care or you may have separate deductibles, one for medical services and a second deductible for prescription drug costs. For example, one silver plan could require you to pay the first $1,000 of your care out-of-pocket; another may have a $500 deductible but will ask you to pay a higher portion of your costs after you spend $500. If you have unanticipated costs, such as an accident or sudden illness, a plan with a large deductible could leave you with significant medical bills.

Each plan website will include information about cost sharing, which may be different for specialist visits than for primary care visits. The amount you pay for a specialist visit could vary significantly from plan to plan. For example, if you are diabetic and regularly see an endocrinologist, you may want to choose a plan with a lower cost for specialist visits. Plans also will require you to share in the cost of prescription medicines. See the *Coverage for Prescription Medications* section of this toolkit for more detail.

Exchange plans may limit the number of times you can utilize certain services during the year. If you seek care from a chiropractor, physical therapist, or mental health professional, for example, be sure to compare across plans to ensure the plan covers enough visits per year to meet your needs.

Provider Networks

Exchange plans must have a network with a sufficient number of providers such as doctors and hospitals. They also must include a sufficient number and geographic distribution of providers who serve predominately low-income, medically underserved individuals.

It's important to understand which health care providers—such as physicians, pharmacies, and hospitals—are in the network of the plan you choose. Plans will have networks of providers from whom you can receive the most affordable care. These networks may include preferred versus non-preferred providers. Preferred providers will charge less out-of-pocket than non-preferred providers. You may not have any coverage for care that you receive from providers who are not in the plan's network. This means that any amount you spend out-of-pocket for providers who are not in your plan's network will not count toward the out-of-pocket maximum.

The exchange website must offer a link to each plan's network of providers. When you are choosing a plan, you may want to make sure that your primary care physician—the person you see for an annual physical or when you have the flu—is in the plan's network. Otherwise, you will have to switch to a participating physician in order to receive the plan's benefits. You should also check to see if any specialists you may need are in the plan's network. Finally, be sure that your preferred pharmacies and hospitals are in-network as well. Checking the provider networks of exchange plans will help you narrow down the options and choose a plan that will best meet your needs.

Coverage for Prescription Medications

Coverage for prescription medications is an important consideration for choosing your health plan. The set of medicines that a plan covers is called the plan's formulary. Formularies often cover medications on different tiers. Each tier has an associated cost-sharing amount. Lower tiers usually have smaller out-of-pocket costs than higher tiers. Plans may have very high out-of-pocket costs associated with therapies covered on higher tiers.

Plans can arrange formularies into many different tier structures. A typical four-tier formulary may have generic medications on Tier 1; preferred brand-name products on Tier 2; non-preferred brand therapies on Tier 3; and specialty or biologic medications on Tier 4. Cost sharing may be a fixed copayment amount for each tier or may be coinsurance, which requires an individual to pay a percentage of the medicine's price. Estimating the amount a person will have to pay in coinsurance may be more difficult, given that a patient may not know the overall cost of each medicine he or she takes.

Understanding whether the medicines you take are covered by your health plan and the out-of-pocket costs for each will help you choose the best plan for you.

QUICK TIPS

- ◊ Estimate your predictable annual health needs.
- ◊ Consider, based on your anticipated health needs and your cost preferences, the right level of coverage for you—Platinum, Gold, Silver, or Bronze.
- ◊ Check to see that the physicians you visit most often are "in network" in the plans you are considering.
- ◊ Review the formulary for the prescriptions you take to understand which plan provides you the best access and least out-of-pocket cost for your medications.
- ◊ Use the *Checklist to Choose a Health Plan* to help weigh your options among the plans available to you.

Conclusion

Enrollment in exchanges begins on October 1, 2013. During the Open Enrollment Period, you will have a chance to sign up for an exchange plan using your state's exchange website, phone hotline, or in-person. If you purchase a plan by December 15, 2013, you will have health insurance coverage beginning January 1, 2014. Open Enrollment ends on March 30, 2014, providing extra time to sign up for health insurance this year only.

When you are comparing options during the Open Enrollment Period, you will likely have many choices. Narrowing down the plan offerings by comparing plan coverage and cost to your expected health care needs will make it easier to pick the plan that is best for you. This guide gives you the tools you will need to choose the best plan for you, so you can have access to the health care you want beginning in 2014.

Additional Resources

- **Premium Assistance Calculator**
  http://kff.org/interactive/subsidy-calculator/
  Kaiser Family Foundation
- **Health Reform Frequently Asked Questions**
  http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/
  Kaiser Family Foundation
- **Welcome to the Marketplace–Exchange Enrollment Consumer Center**
  https://www.healthcare.gov/marketplace/individual/
  Healthcare.gov

Note: The purpose of this tool is to describe some of the factors a patient may wish to use to evaluate health plans. Each person should make an independent decision about his/her selection of a plan based on individual circumstances and adequacy of coverage in consultation with trusted advisors.

Other information is available through your state's Exchange.

Appendix: Premium and Cost-Sharing Subsidies

Premium Subsidies: Sliding scale tax credits to limit premium spending as a percent of income for individuals under 400% FPL; Applies to the second lowest cost Silver plan available in the exchange

Income (% FPL)	Income Range for Individual	Premiums Limited to % of Income	Estimated Annual Premium Cost (assuming $5,200 Silver annual premium)
	Individual Coverage		
100 up to 133% FPL[1]	$11,490 – $15,282	2.0%	$230 – $306
133 up to 150% FPL	$15,282 – $17,235	3.0 - 4.0%	$458 – $689
150 up to 200% FPL	$17,235 – $22,980	4.0 – 6.3%	$689 – $1,448
200 up to 250% FPL	$22,980 – $28,725	6.3 – 8.05%	$1,448 – $2,312
250 up to 300% FPL	$28,725 – $34,470	8.05 – 9.5%	$2,312 – $3,275
300 up to 400% FPL	$34,470 – $45,960	9.5%	$3,275 – $4,366

Cost-Sharing Subsidies: Provides cost-sharing subsidies for individuals with incomes below 250% FPL

Household Income	OOP Limit	Average percent of total cost paid by health plan
100 – 150% FPL	$2,250	94%
150 – 200% FPL	$2,250	87%
200 – 250% FPL	$5,200	73%
250 – 400% FPL	$6,350	70%

FPL = Federal Poverty Level
OOP = Out-of-Pocket
According to 2013 figures, 100% of FPL for an individual is $11,490 and for a family of 4 is $23,550
1. In some states individuals in this income group will be eligible for Medicaid and will receive coverage through that program instead of through Exchange premium subsidies.

Choosing a Plan in the New Health Insurance Marketplaces

Under the Affordable Care Act, individuals have the opportunity to choose health insurance plans from federal and state exchanges. The open enrollment period for the new health care exchanges began on October 1, 2013, and as widely reported, access to the exchange websites was limited by shortcomings in the design of those websites. Importantly, in order to gain coverage by January 1, patients must sign up on the exchange sites by December 23, 2013. Therefore, as federal and state governments fix the consumer websites, it is critical that patients understand the many factors that should be considered when choosing a plan to ensure they can quickly and effectively make the best choice in coverage. The exchanges offer many plans to meet the unique needs of each individual – but with this expanded choice comes the need for patients to carefully consider a range of concerns. Obviously premium costs are a major consideration, but due to the structure of most insurance plans, consumers also need to carefully consider cost sharing in the form of deductibles, copayments, and coinsurance.

What Is Cost Sharing?

The term "cost sharing" refers to the amount that patients pay out-of-pocket rather than have covered by insurance when they need a health care service. Cost sharing often is disproportionately high for prescription medicines, with patients needing medicines often paying a much larger share of the cost than patients needing other types of health care, like a hospitalization.[i]

Prescription drug coverage, in particular, varies widely across the exchange plans. Therefore, patients who regularly rely on prescription medicines, or expect to need them in the future, should ensure cost-sharing is carefully considered when choosing an insurance plan. Failure to evaluate the future cost of prescription medications could present a significant obstacle to the appropriate treatment of many chronic and acute conditions.[ii], [iii] Choosing a plan that offers affordable medications could increase patient access to treatments in the future and ensure they are able to take prescribed medications as prescribed by physicians.[iv], [v]

How Should this Impact Plan Selection?

Initial reviews of plans offered via the exchange marketplaces suggest that cost sharing in exchange plans will be somewhat higher than what is typically observed in employer-sponsored health insurance plans. When choosing a plan, patients will need to pay close attention to the following considerations:

- ***The vast majority of exchange plans will require patients to meet an annual deductible.*** The term "deductible" refers to a set dollar amount that must be paid out-of-pocket before an insurer pays for any expenses. Patients seeking exchange coverage should recognize that they will likely be required to satisfy either a prescription drug deductible or an integrated medical/drug deductible before any coverage for prescription medicines is available.[vi]

  In a recent survey of exchange plans, about 85% included an integrated deductible, under which both medical and drug expenses accumulate toward a single annual deductible.[vii] From a sample of about 200 "silver" plans, the average deductible was about $2,600, while some plans included deductibles as high as $6,000.[viii] The average integrated deductible for individuals with employer-sponsored health insurance plans was $1,135 in 2013 and only 15% of individuals with employer-based health insurance faced an annual deductible greater than $2,000.[ix] Therefore, it is critical to evaluate consumer's ability to meet a higher annual deductible when evaluating plan choices.

- ***Even after meeting the deductible, exchange plan enrollees will face out-of-pocket expenses for medicines.*** Under the exchange plans, even after patients meet a plan deductible, they will still be subject to copayments or coinsurance for prescription medications. Based on initial reviews, patients will be responsible for a larger share of the cost of prescriptions under the exchanges than they typically were under employer-sponsored health insurance. Increases in copayments and coinsurance can ultimately mean a significant increase in out of pocket costs and should be carefully weighed when determining overall plan costs.

  While the typical copayment for preferred brand medicines under employer-sponsored health plans was $29 in 2012,[x] many bronze and silver plans will charge $30-$50 for each preferred medicine.[xi],[xii] For patients subject to copayments for non-preferred brand medicines, they will be expected to pay between $40 and $90 for each medication; however, many exchange plans will expect patients to meet a coinsurance requirement, rather than a flat copayment, for non-preferred medicines.[xiii]
  The term "coinsurance" refers to the patient's share of the cost of a prescription medicine, expressed as a percent. If a plan requires coinsurance of 30% for a non-preferred medicine, then the patient is responsible for paying 30% of the cost of the medicine. The use of coinsurance can further increase the out-of-pocket expenses required of patients, especially those who require innovative medicines.

- ***Because of the increase in out-of-pocket expenses, cost sharing can hit low-income and chronically-ill patients the hardest.*** For many low-income individuals and families with limited or no disposable income, cost-sharing requirements may result in significant financial strain. This issue is of significant concern considering the Congressional Budget Office predicts that approximately 80% of the individuals who enroll in exchanges in 2014 will be eligible for premium subsidies and thus have incomes between 100% and 400% of the federal poverty level.[xiv] Moreover, households with a chronically ill family member rely on more prescription medicines. Because these medications are less generously covered than things like hospital stays, chronically ill patients face higher out-of-pocket burdens than those without a chronic condition.[xv] Therefore, patients who fall into either of these categories should carefully determine their ability to address out-of-pocket costs when evaluating exchange plan options.

- ***Exchange plans enrollees who use specialty medicines could face increased costs due to coinsurance requirements.*** Patients who utilize specialty medicines to treat serious and complex conditions like cancer, rheumatoid arthritis, and multiple sclerosis, should take great care in choosing an exchange plan. Like many commercial health plans, the majority of exchange plans will assign high cost sharing to specialty medicines, which concentrates costs onto patients who require them, rather than spreading more of the cost as is typically done with patients needing hospital care. [xvi] The exchange plan specialty tiers will require coinsurance rates for specialty medicines in the range of 30-50%, as opposed to the 25-33% coinsurance rates seen by Medicare Part D patients.[xvii],[xviii],[xix],[xx] Considering the average coinsurance rate in the commercial market is 32%, patients moving from a commercial plan to an exchange plan could experience higher cost sharing for specialty medications..[xxi]

- ***Ensuring patients have access to medications is critical to improving overall health and ensuring long-term well-being.*** High cost sharing can pose a significant financial burden; however, if those costs prevent patients from filling prescriptions, they will often suffer from poorer health and higher incidence of complications. Therefore, it is critical to take all costs associated with a plan – not just the required premiums – into account when assessing total expense.[xxii], [xxiii]

When shopping for health coverage on the exchanges, it is critical that patients look beyond low premium costs and consider how plan selection will impact out-of-pocket expenses for prescription medicines based on the guidelines outlined above. Although the ACA imposes annual caps on patient out-of-pocket spending, many times those annual caps are burdensome for covered individuals. By carefully reviewing the available plans, patients will be able to ensure they receive comprehensive health coverage that includes affordable access to prescription medicines.

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Coverage for Prescription Medicines in Essential Health Benefits: A Toolkit for Advocates

As the Affordable Care Act (ACA) coverage expansions take effect in 2014, comprehensive health insurance, including prescription medicine coverage will be available for nearly all Americans. Federal rules for essential health benefits (EHB) requirements leave significant flexibility to the states regarding enforcement and additional health plan requirements. Patient advocates have the opportunity to play an important role in engaging with states to ensure that patients enrolled in EHB plans have appropriate access to necessary medicines at an affordable cost.

This toolkit focuses on the health insurance exchanges (also known as marketplaces) that were created by the ACA with the aim of providing an improved and standardized health insurance shopping experience for individuals and small employers. This guide begins with an overview of the essential health benefits (EHB) and State and Federal requirements for prescription drug coverage in states. The next section reviews existing patient protections set forth by the federal government and identifies opportunities for advocates to strengthen patient protections at the state level. The third section offers guidance on how advocates can affect change in exchanges, including the types of decision makers to target for engagement, state models for exchange implementation, and vehicles for making prescription medicine coverage changes in each state. The final section lists decision makers in each state who advocates can contact in an effort to improve exchange coverage. This toolkit does not cover the process of how benefits for those newly eligible for Medicaid will be determined. However, some of the topics included in this document also may be relevant to patient advocates seeking to ensure good access for those beneficiaries.

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Overview of Essential Health Benefits

The Affordable Care Act (ACA) included new requirements for health plans to cover a core group of medical benefits and services, called the essential health benefits (EHB). The ACA requires all individual and small group health plans beginning in 2014 to cover EHBs—a set of ten categories of healthcare services.[i] The ten categories of healthcare services include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription medicines, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

The law requires EHB coverage to be equal to the scope of benefits provided by a typical employer plan. Via regulation, the Centers for Medicare & Medicaid Services (CMS) tied the scope of EHB to a state-selected benchmark plan.

Identifying the State Benchmark Plan

CMS gave states an opportunity to select a benchmark plan to set the minimum standards for breadth of coverage under EHB in the state. States selected a benchmark plan among four different types of plans:

1) One of the three largest small group plans in the state by enrollment;
2) One of the three largest state employee health benefit plans by enrollment;
3) One of the three largest national Federal Employee Health Benefits Program (FEHBP) plan options by enrollment; or
4) The largest health maintenance organization (HMO) plan offered in the state's commercial market by enrollment.

For states failing to select a benchmark, the benchmark defaulted to the largest plan by enrollment in the state small group market. Either through selection or by default, the overwhelming majority of states will have a small group plan as their EHB benchmark. Conversely, no state has selected the FEHBP plan option for 2014.

Additionally, states must ensure that all 10 required benefit categories outlined in the ACA are covered. If the selected benchmark plan does not include the 10 required service categories, states must supplement the missing benefit categories with those from other plans.

What You Can Do

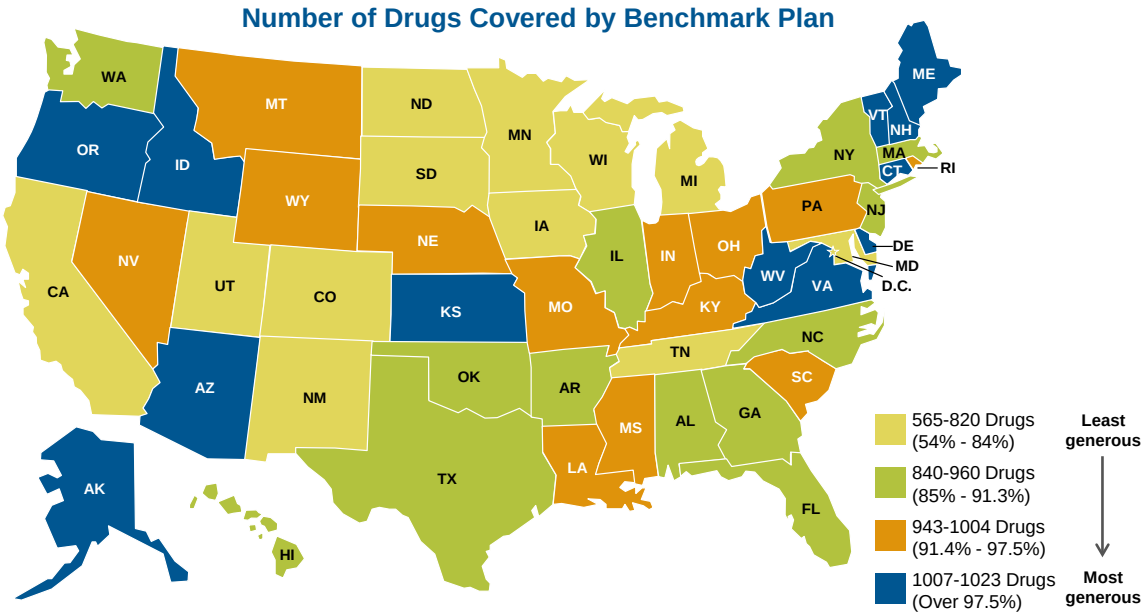
Know what plan is the EHB benchmark in your state (see List of Key Decision Makers table, starting on page 19)

Assess whether the benchmark plan adequately covers the services most commonly used by your priority patients.

Prescription Drug Coverage in EHB

CMS requires health plans to cover at least the number of prescription medicines in each United States Pharmacopeia (USP) category and class as the state's EHB benchmark. In cases where the benchmark does not cover any medicines in a class, EHB plans are still required to cover one medicine in that class. Plans do not need to match the specific medicines covered on formulary for the benchmark plan but must cover at least as many products in the class. To count toward coverage requirements, CMS has stated that medicines must be "distinct chemical entities." The CMS definition of distinct chemical entities ignores many key differences between medicines, potentially leading to exchange plans having narrower formularies than the benchmark plans.

Benchmark formularies themselves vary widely across state benchmark plans. Out of the 1,032 total distinct chemical entities available on the market, EHB benchmark plans cover a minimum of 565 (55 percent) in Colorado to a maximum of 1023 (99 percent) in Connecticut. Some large states, including California, Michigan, and Wisconsin, fall into the lowest quartile of formulary breadth in their benchmark plans. That said, coverage along this continuum is not evenly distributed; more than half of states have an EHB benchmark that covers at least 90 percent of total distinct chemical entities.



* Based on data released by CMS on state selected benchmark plans, February 20, 2013, available at http://cciio.cms.gov/resources/data/ehb.html. Maximum potential medicine count is 1032; totals may double-count medicines that are categorized in more than one USP class.

Despite the relatively broad benchmark formularies in many states, CMS' prescription medicine counting methodology could threaten patient access to critical innovations in medication therapy. As currently understood, the EHB rules and its use of the USP classification system do not assure good coverage of combination therapies, extended release therapies, medical benefit products, and newly approved medicines.

Combination Therapies. CMS counts combination products only if an individual component of the medicine is not commercially available as a stand-along product or when the components combine to form a unique chemical entity.

- Over the previous decade, combination products have become increasingly vital treatment options for serious conditions, such as HIV/AIDS. Combination therapies reduce pill burden and increase compliance for HIV/AIDS patients, who are often taking multiple medicines several times per day and are now considered the standard of care.

Extended Release Therapies. CMS rules do not recognize differences between extended release and conventional dosage forms of a single medicine.

- Therapies with time release technology, including extended release products, are commonly prescribed and often used in the treatment of mental health conditions. These products result in a more even release of the medicine into the bloodstream, allow patients to take medications less frequently, and maintain better control of their condition.

Medicines Not Included in USP. The USP model guidelines were developed for the Medicare Part D program and, as a result, do not include some classes of medicines not covered by Medicare, like contraception or weight loss medicines.

- Some medication classes not covered by Medicare are a standard part of most employer plans and should be included in the EHB benchmark. States should consider additional formulary reviews that supplement USP using the American Society of Health-System Pharmacists' AHFS (American Hospital Formulary Service) classification system that is widely used in the commercial market.
- Inclusion of weight loss medications in formularies should be reviewed by states taking into consideration the American Medical Association's recent decision to recognize obesity as a disease.

Therapies Covered Under the Medical Benefit. CMS did not specifically include medicines covered under the medical benefit instead of the pharmacy benefit in their coverage requirements for plans.

- With no minimum standard for medical benefit products, patients with certain conditions whose treatment regimens include medical benefit medicines will not be assured access to these products.
- Unclear instructions to state benchmark plans on whether medical benefit therapies should be included in their formularies resulted in inconsistent EHB benchmark formulary counts across states.
- Patients may experience access challenges for different medicines in a single class that are distributed either by pharmacies or physicians under a plan's medical benefit.

Newly Approved Medicines. The Department of Health and Human Services has not released guidance related to coverage of newly approved medicines or coverage of medicines that are FDA-approved in the middle of the benefit year.

- Plans are not required to update their formularies during 2014 or 2015 and EHB benchmark requirements are tied to 2012 formularies.
- While plans have flexibility to add new medicines to their formulary mid-year, it is not required.
- Plans also could remove a medicine when adding a new medicine to the formulary, as long as they meet the medicine count for the class.

Broad USP classes. The use of USP as the classification system upon which the counting methodology is designed creates its own access challenges. The USP classification system

uses relatively broad classes, increasing the possibility that a patient may not be able to substitute one treatment in a class for another.

What You Can Do

Determine which USP classes are more commonly used by your patient population and which medicines are included in those classes.

Evaluate how the CMS definition of unique chemical entities will impact the medication classes that are most important for your patient population.

Identify gaps in minimum EHB requirements for medication coverage for existing and new therapies.

Encourage CMS and states to safeguard access to innovative therapies by establishing guidelines and processes for health insurers to make available to their members new medicines introduced to the market in the middle of the benefit year.

Actuarial Value and the Impact on Cost Sharing

Plans operating in the exchanges must cover a certain percentage of covered healthcare costs in order to comply with the set actuarial values (AV). The ACA establishes set actuarial values and defines AV as the percent of healthcare costs covered by the health plans for a typical group of beneficiaries. Plans can offer one of four different plan types in terms of actuarial value from Bronze to Platinum.

Actuarial Values for Exchange Plans by Metal Levels

Bronze	Plan covers 60% of healthcare costs
Silver	70% of healthcare costs
Gold	80% of healthcare costs
Platinum	90% of healthcare costs

Many policy and exchange market experts predict that most enrollees will select either a Silver or Bronze plan. Even under a Silver plan, enrollees will be responsible for covering up to 30 percent of their healthcare costs. Compared to employer-sponsored plans, the actuarial values for the Bronze and Silver plans are relatively low. The typical employer preferred provider organization (PPO) plan has an actuarial value between 80 and 84 percent, which will be similar to Gold coverage under EHB.[ii]

In addition to the actuarial values listed above, all plans will need to include a maximum out-of-pocket limit. In 2014 the annual limit will be $6,350 for an individual and $12,700 for a family. Those limits are reduced for individuals earning less than 250 percent of the poverty level.

Many important aspects of a health plan are not included in actuarial value calculations. Actuarial value does not account for the breadth of a health plan's formulary or its provider network. Similarly, actuarial value calculations do not include out-of-pocket costs for treatments not covered by the health plan. CMS has decided to exclude out-of-pocket costs for out-of-network providers from the actuarial value calculations. CMS's actuarial value calculations will

also only account for the cost-sharing amount assigned to each tier of a plan's formulary, which means that a plan with relatively few medicines on the specialty tier could have the same AV as a plan that places a much higher share of medicines on the specialty tier.

Cost Sharing in State Standardized Benefit Designs

Health plans will need to adhere to one of the four metal levels described above. However, they will have flexibility to set deductibles and cost-sharing levels for specific services. A few states have attempted to increase the consistency of benefit designs by creating a set of standardized products for each metal tier that all insurers must offer.[iii] To date, six states—CA, CT, MA, NY, OR, and VT—have released documents describing their proposals for standardized plan benefit designs. In states where benefit designs are not standardized, it will be important for patients to consider which benefit structures will leave them with the lowest overall costs. For example, a patient who needs several brand medicines should look closely at the plan formularies while a patient not taking prescription medicines but who regularly sees a specialist should emphasize the provider network and the required cost sharing for a specialist visit when shopping for a plan.

State	Plan Type	Benefit Cost-Sharing Parameters*								
				Drug Formulary						
		Overall Deductible	Drug Deductible	Tier 1	Tier 2	Tier 3	Tier 4	Inpatient	Specialist	OOP Max for Drugs
CA	Silver Copay†	Medical: $2,000	$250‡	$25	$50	$70	20%	20%	$65	N/A
	Silver Coinsurance†	Medical: $2,000	$250‡	$25	$50	$70	20%	20%	$65	N/A
CT	Silver	Medical: $3,000	$400	$10	$25	$40	40%	$500	$45	N/A
MA	Silver	$2,000	N/A	$20§	$35§	$70§	N/A	$1,000	$50	N/A
NY	Silver	$2,000	N/A	$10§	$35§	$70§	N/A	$1,500	$50	N/A
OR	Silver	Medical: $2,500	$0	$15	$50	50%	50%	30%	$70	N/A
VT	Silver Deductible	Medical: $1,900	$100‡	$12	$50	50%	N/A	40%	$40	$1,250
	Silver HDHP	Medical: $1,550	$1,250	$10	$40	50%	N/A	20%	20%	$1,250

*Benefit cost-sharing parameters are specific to individuals. Deductibles and OOP cap may be higher for family coverage.
†California's silver copay and coinsurance plan designs vary in cost sharing for advanced imaging and home health care services as well as in the accumulation of certain cost sharing towards the deductible
‡For brand medicines only
§Parameters vary for mail-order pharmacies

As shown in the table above, cost sharing for prescription medicines on Tier 4 may be quite high, ranging from a low of 20 percent coinsurance for top tier prescription medicines to a high of 50 percent in Oregon.

What You Can Do

Understand how EHB plans can vary even when they have the same actuarial value.

Identify threats to patient access and adherence resulting from high cost-sharing.

Consider what metal level of EHB plan and what type of benefit design is likely to be most cost-effective for your patient population.

Patient Protections in EHB and Exchanges

In defining the essential health benefits, the ACA requires the federal government to:

- Ensure that the EHB package reflects an appropriate balance among the ten categories, so that benefits are not unduly weighted toward any category;
- Not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, degree of medical dependency, or expected length of life;
- Take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups; and
- Ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life.

Aside from these broad guidelines, the ACA remains silent on the specifics of how these parameters would be designed or enforced. However, the inclusion of these parameters in the ACA establishes a clear role for the federal government to consider patient protections as a part of EHB, either through design or oversight.

The ACA established EHBs to improve and standardize health care coverage in the individual and small group health insurance marketplaces. As the federal government has partnered with states to define and implement the EHB, the role that states play in creating and enforcing standards for these plans is larger than ever before. With this increased power of state decisions comes even greater responsibility—to ensure that plans operating in the individual and small group markets meet the needs of all individuals, from the healthiest to those with chronic and disabling conditions. States have many policy options to consider that would help ensure EHB plans fulfill these diverse objectives.

Improving Prescription Medicine Access Standards

This section outlines key areas for improving patient protections on prescription drug coverage in essential benefits. At the end, it includes **proactive policy solutions** that you can promote within states to improve medication access and adherence for patients.

Prescription medicine count requirements, as discussed above, will ensure that formulary coverage in EHB plans meets the minimum standard established by the state's benchmark, though these requirements are not comprehensive. The formulary coverage standard set by the benchmark may not include combination therapies, extended release therapies, medical benefit

products, and newly approved medicines. Additionally, though these coverage standards are quite clear, the regulation does not offer additional requirements to ensure adequate patient access to medications within these EHB plans.

Coverage on a health plan's formulary is a critical component of ensuring access to medications. However, factors such as tiering, cost sharing, and utilization management also have an enormous influence on whether patients can actually access needed medications. EHB plans are expected to use tiered formularies—with a co-pay or coinsurance level assigned to each tier—to encourage utilization of medications with lower out-of-pocket costs.

Federal regulations and guidance have been silent on how plans may dispense medications across their tiers, with no requirements that a covered class of medications have even a single "preferred" medicine available at lower cost sharing. Additionally, with no limit on the cost assigned to any tier, plans may have cost sharing at or above 50 percent coinsurance for Tier 3 and Tier 4 medications. Even when plans meet the coverage requirements of the benchmark, EHB plans' tiering structure and cost sharing requirements may result in insured patients who cannot afford the out-of-pocket costs of their necessary prescribed medications.

Lastly, EHB plans are permitted to apply formulary benefit management tools, known as utilization management (UM). These UM techniques, including step therapy and prior authorization, can inhibit access to needed medications if the practices are not clinically appropriate. The ACA specifically permits EHB plans to employ commonly used UM techniques; however the EHB regulation offers no limits on use of UM aside from a mention that use of such techniques must be reasonable and evidence-based.

Though the federal government has created standards and enforcement mechanisms to ensure EHB plan formularies meet coverage standards, there are no such requirements on other aspects of plan design that could limit access. Appropriate patient access to medications in EHB plans is likely to be limited without review of tiering, cost sharing, and utilization management.

What You Can Do

Examine the benchmark plan's formulary for coverage of classes of medications commonly used by your priority patients. This would ensure that patients who would be likely to encounter discriminatory plan design would have many options for treatment.

Review access to medical-benefit therapies in plan materials. For future plan years, consider advocating for rules to ensure appropriate access to medical-benefit therapies.

Encourage states to consider the combination of coverage, cost sharing, and utilization management when reviewing plan formularies for certification.

Promoting Transparent Plan Details

While health plans sold in exchanges must fall into one of four metal levels (Bronze through Platinum), plans still have significant flexibility to design their benefit packages, including formulary breadth, utilization management, and cost-sharing. As such, a patient may find that his or her total out-of-pocket costs will differ widely by plan. Enrollees may be able to get coverage for some of their current medications at a lower cost by selecting the right health plan for them.

For many people, making an informed choice about health insurance plan selection will be a challenge. Enrollees must weigh monthly premium, provider network, formulary, and cost-sharing to optimize their plan selection. Navigators and other one-on-one assistance programs will be available to people shopping for health insurance. Even so, the limited transparency of key plan coverage and design details may inhibit the ability of these programs to offer further clarity to patients.

Federal rules leave broad flexibility to states when designing their exchange websites. Websites will not be required to include tools that allow consumers to search for plans that cover specific prescription medicines or include particular physicians or pharmacies in their network. The federal government only requires that websites include links to summary of benefits and coverage documents that contain information about a given plan's pharmacy benefit medication coverage and network. Plans' coverage policies for therapies covered through the medical benefit may be even harder to determine.

In addition to the challenges patients will face in shopping for health insurance coverage, the current rules do not require plans to maintain the same formulary throughout the benefit year. This could result in patients enrolling in a health plan that covers all of their medications at the beginning of the plan year but changes formularies mid-year, leaving the enrollee with no coverage for a particular medication. Additionally, the patient would not be permitted to change enrollment into a more appropriate plan mid-year, since there are no special enrollment periods for this reason and the open enrollment period is an annual occurrence.

In order for consumers to make informed choices about their exchange coverage, exchange websites should include full transparency on prescription drug coverage, including cost sharing and utilization management requirements as well as information about pharmacy networks. Online tools can further help enrollees estimate their annual out-of-pocket costs for expected medical services and prescriptions in competing plans. Further, since patients are locked into enrollment into one health plan for the entire year, health plans, similarly, should be limited in the types of changes they can make to formularies mid-year.

What You Can Do

Promote the inclusion of detailed data on the exchange website for consumers, including searchable formularies with cost-sharing and utilization management information to improve the transparency of information related to prescription medication coverage.

Encourage states to include a calculation of expected total out-of-pocket costs on exchange website or provide the calculations through navigators/assistors.

Work with states to limit mid-year coverage changes by exchange plans so enrollees do not experience a "bait-and-switch."

Ensuring Plans Do Not Discriminate

As described above, the ACA requires that EHB plans not discriminate against any individual on the basis of age, expected length of life, present or predicted disability, degree of medical dependency, or quality of life. At least for states in which the federal government is responsible for exchange implementation, CMS will evaluate health plans for non-discrimination through the use of a test to identify plans that are outliers in terms of cost sharing across several categories

of benefits, including prescription medicines. Through this outlier identification process, CMS will identify health plans to target for further scrutiny of discriminatory plan design. To date, the federal government has released no details about the specific processes it will use to identify outliers or what steps would be taken to further scrutinize plans that are identified in the outlier test.

Additional reviews beyond these outlier tests could help CMS examine plans' structures for discriminatory design. For example, CMS could review formulary structures to ensure that the benefits are not biased against patients with high medication costs in favor of other medical benefits. Additionally, some formulary structures, such as brand-only deductibles, should be considered inherently biased and banned from use.

In addition to the outlier identification process, CMS also will review information from health plans' submitted application, particularly in the "explanations" and "exclusions" sections, to identify discriminatory practices or wording. Finally, CMS will collect attestations that issuers' QHPs will not discriminate against individuals on the basis of health status, race, color, national origin, disability, age, sex, gender identity, or sexual orientation, as required by federal law.

For the 16 states operating their own state-based exchange, all rules governing non-discrimination as well as the processes for enforcement of non-discrimination must be developed by the state. These states should develop written plans detailing the processes they will use to enforce non-discrimination provisions and assess/evaluate outliers.

What You Can Do

Promote clear policies defining discriminatory practices and benefit designs, as well as procedures for identifying discrimination in plan benefits. Work with states to develop reviews for potential discrimination that are more intensive than federal outlier tests.

Review plan materials and notify exchanges about benefit designs with poor coverage of expensive services or cost-sharing arrangements that disproportionately shift costs to patients with expensive health conditions.

Supporting High-Quality Plans

The ACA requires health plans to meet quality standards, by gaining and maintaining accreditation and implementing a quality improvement strategy. Additionally, the law establishes a role for exchanges in promoting quality by requiring that they: 1) ensure that health plans meet accreditation requirements; 2) establish ratings based on plan quality and cost; and 3) provide patient satisfaction data. It is important for patients to have assurance that plans meet the required quality standards and exchanges are performing appropriate oversight of the quality of the health plans operating in their states.

The quality rating system that CMS is developing is expected to launch in 2016. However, since exchanges will be operational in 2014, there will be a two-year gap before the federal system is in place. During that two-year gap, some plan quality information will be available, and offering access to these details may help patients make more informed decisions while they are shopping for health insurance coverage. Examples of these available details include a plan's accreditation status; performance on certain clinical measures (e.g., childhood immunizations, preventive screenings for cancer and effective monitoring, and management of chronic

conditions such as diabetes); and data on patients' experience with their health plans. Some states have used "report cards" on health plans, and these may be a good model for states to use in 2014 and 2015 until the federal quality rating system is in place.

What You Can Do

Advocate for a quality measurement and reporting program to evaluate plans before the federal system is ready in 2016

In states operating state-based exchanges, encourage accreditation requirements that mirror the FFEs

Promote the use of widely used and NQF- endorsed metrics, such as prescription medication adherence; enrollee complaints and satisfaction; and NQF-endorsed outcome measures for key chronic conditions, as components of the plan rating system

Require plans to achieve certification before 2016, based on measures that do not require access to a full year of plan data

Aligning Grievances, Exceptions, and Appeals Processes

The availability of a system to file and resolve complaints is an important patient protection required of health plans. To date, CMS has released limited information on the grievance and complaints process for health plans. Health plans will be responsible for investigating and resolving complaints, and CMS expects complaint resolution to be timely. Additionally, though details are not yet available, CMS will track complaints through a centralized system and use the aggregated information collected to guide oversight activities in the federally facilitated and partnership exchanges. While these systems offer patients the promise of valuable protections, the yet-to-be-announced details will reveal whether the systems will offer more protections to patients or, conversely, yield flexibility to health plans.

A second patient protection introduced in CMS regulation on EHB requires health plans that provide EHB to allow enrollees to request and access clinically appropriate medicines not covered by the plan. Similar to the Medicare Part D standard for exceptions, plans should cover off-formulary medications if the prescriber submits a statement that the requested prescription is clinically appropriate because the covered medication(s) for the same condition would not be as effective as the prescribed medication and/or would have adverse effects. Notably, CMS also strongly encourages health plans to allow enrollees who have requested such exceptions access to the medication in dispute during the entire exceptions request process. Additionally, if the health plan grants an enrollee an exception, the health plan should allow the enrollee to have access to the medication at issue throughout the individual's enrollment in the health plan. The exceptions process is a critical protection for patients enrolled in health plans. However, the lack of standardization for processes or timing could result in minimal assistance to patients. Patient notification requirements and a uniform exceptions form could ensure that the exceptions process is patient-focused.

A final patient protection is the ACA requirement that all non-grandfathered small group, large group, and individual health insurance plans adopt standardized processes for internal appeals and external reviews. For coverage of prescription medicines, the processes for internal appeals and external reviews apply both to adverse coverage decisions for a medication on the health

plan's formulary as well as formulary exceptions requests. Plans also must provide to enrollees notice of the right to appeal and instructions regarding how to file an appeal both upon applying for health insurance coverage as well as upon an adverse coverage decision by the plan. Though standardized processes for appeals and reviews are important protections for patients, further standardization across all plans in a state could improve transparency and lead to better patient outcomes.

What You Can Do

Work with states to standardize the processes and forms for all exchange plans for grievances, exceptions, and appeals.

Advocate for the public release of data on applications and outcomes for grievances, exceptions, and appeals for all exchange plans.

State Policy Options for Improving Patient Protections in EHB

Improving Plan Review Process:

- Adopt principles related to non-discrimination in exchange operating guidelines.
- Develop a written state plan to enforce non-discrimination provisions and assess/evaluate outliers, using CMS-provided tests or state-developed alternatives.
- Do not allow brand-only deductibles, as these are discriminatory.
- Develop a mechanism to adjust plan drug counts provided by the CMS drug counting tool to consistently correct misleading counts (for physician-administered drugs, combination and extended release products, and products that do not have a USP class).
- Establish a Quality Oversight Committee of public and private stakeholders to manage quality measure selection and assure public reporting on quality.

Promoting Transparent Plan Details:

- Provide detailed data on the website for consumers, including searchable formularies with cost-sharing and utilization management information to improve transparency of information related to drug coverage – similar to CMS Part D plan finder.
- Create an out-of-pocket cost calculator on the exchange website.
- Limit the use of mid-year formulary changes and establish rules for plans to notify enrollees about mid-year formulary changes.

State Policy Options for Improving Patient Protections in EHB (continued)

Supporting High-Quality Plans

- Develop a quality measurement and reporting program to evaluate plans, with public reporting beginning as soon as possible. Consider using Medicare Advantage as a model for this measurement and reporting.
- Require accreditation of all plans at least as soon as federally facilitated Exchanges, with strong policy and procedure requirements beginning in the 2014 plan year—including minimum standards typical of commercial market coverage regarding: updating of formularies, make up of Pharmacy and Therapeutics (P & T) committees; medical/scientific evidence underlying utilization management determinations; exceptions and appeals procedures, etc.
- Plan rating program should include widely used and National Quality Forum (NQF) endorsed metrics, such as measures that address:
  - prescription drug adherence;
  - enrollee complaints and satisfaction
  - NQF-endorsed outcome measures for key chronic conditions

Aligning Grievances, Exceptions, and Appeals Processes:

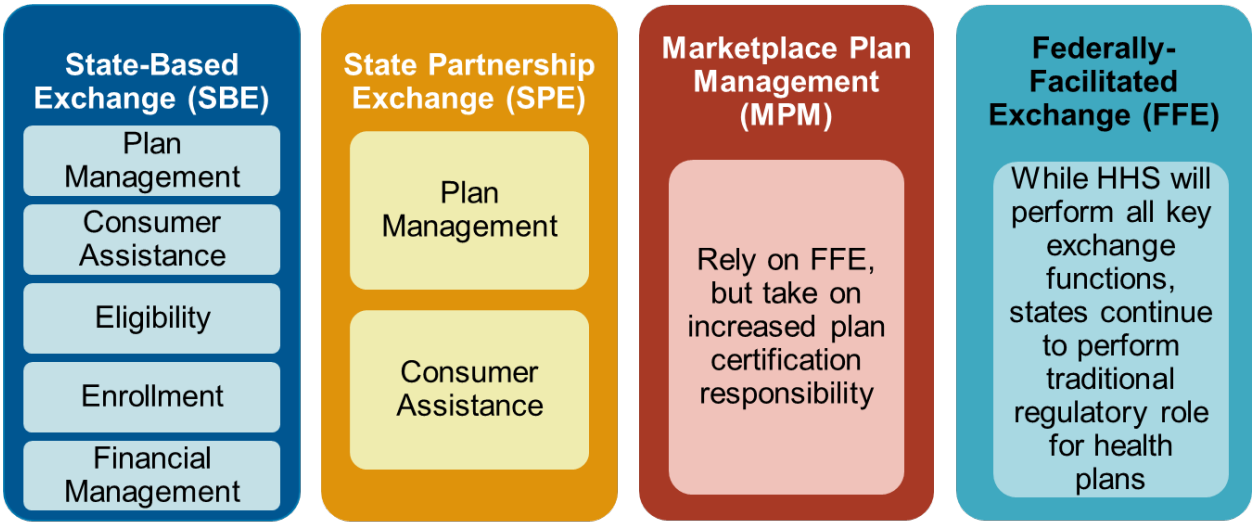
- Require plans to adhere to a standard appeals and grievances process.
- Set minimum review times for plans to make decisions on patient grievances, exceptions, and appeals.
- Appoint a state exchange ombudsman to advocate for patient rights.
- Require QHPs to honor appeals, prior authorization and step therapy decisions from other health plans to ensure patients do not need to repeat these processes if they change plans.

Effecting Change in Exchanges: Key Questions & Checklist for Engaging with States

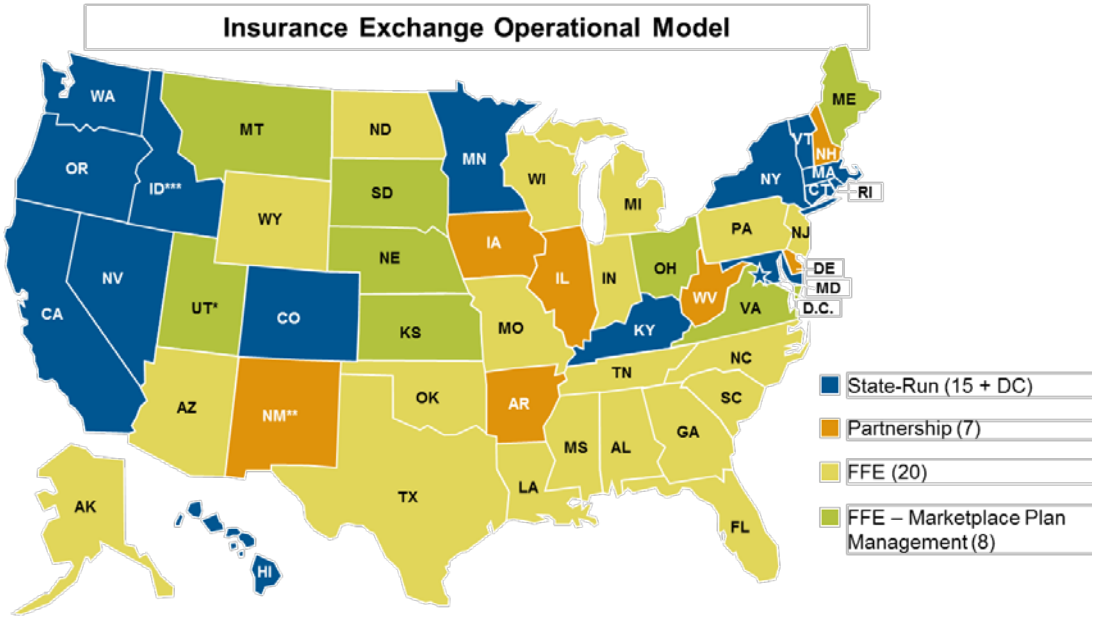
How does a state's exchange operational model impact its approach to benefit design?

When originally approved, the ACA envisioned having most states operate their own exchanges. The law created a fallback option for the federal government to run exchanges in states that do not do so themselves. However, as a result of time constraints or political opposition, a majority of states will rely on the federal government for some or all of their exchange functions in 2104.

Fifteen states and the District of Columbia will operate state-run exchanges in 2014. These states will be responsible for all functionality from setting requirements for health plan participation to building IT systems responsible for conducting subsidy eligibility determinations and enrolling applicants into health plans. Partnership exchange states will maintain some control over plan management and/or consumer assistance functions, while delegating operational elements related to eligibility, enrollment, and financial management to the federal government. Similarly, marketplace plan management states are like the partnership model, but will only influence plan certification. Last, in states relying fully on the federally facilitated exchange (FFE), the federal government will perform all exchange functions.



The map below shows each state's exchange operational model for 2014. To change models, states need to notify the federal government 13 months in advance of the benefit year, e.g., in November 2013 to change approaches for 2015.



Understanding each state's exchange operational model will be crucial for effecting change on EHB. State-run exchanges may be more likely to impose additional benefit requirements on health plans that will improve patient access to medicines. However, states with federal and partnership exchanges can also influence benefit design through improved oversight by the Department of Insurance. Key stakeholders responsible for essential benefits decisions will also vary in each operational model, and these differences are described in the next question.

What You Can Do

Understand each state's exchange operational model.

Build customized strategies for achieving advocacy goals in state-run, partnership, and FFE states.

How do various state officials influence benefit designs in exchanges?

Across exchange operational models, several different state officials can influence the benefit design and consumer protections available in exchange products.

Exchange Boards. State-run exchanges are required to have boards that make decisions on rules and functionality in the exchange. These boards represent an important stakeholder group that can influence coverage in these new markets. Exchange boards may set additional benefit design requirements for QHPs, impose patient protections that exceed federal minimums, and oversee market trends to protect against discriminatory design or behavior. As a result, exchange boards are likely to be the most important stakeholder for state-run exchange states.

Departments of Insurance. Even though most states do not have an exchange board and will rely on the federal government for some or all functionality, the states will still play a vital role in shaping benefit design. State Departments of Insurance (DOI) are responsible for reviewing and approving all products (other than self-insured plans) sold in state markets. New federal ACA regulations governing the individual and small group markets expand the scope of DOI

responsibility and leave significant discretion to state DOIs for enforcing federal rules. As such, building relationships with insurance commissioners and other DOI staff in both state-run and federally operated exchanges presents an important opportunity to influence these markets.

Governors & Legislatures. Outside of the expanded role for exchange boards and DOIs, governors and legislatures remain important allies for state advocates when influencing exchanges. These decision makers have power to pass legislation imposing stronger patient protections for coverage of prescription drugs and may be able to impact decisions by the exchange board or insurance commissioner.

Summary of Key Influencers on Exchange Benefit Design

	Exchange Function	Scope of Authority
Exchange Board	Primary decision-maker for state-run exchanges	• Establish additional QHP requirements for exchange participation, such as standard benefit design, formulary coverage requirements, or cost-sharing restrictions • Certify QHPs as meeting all exchange rules • Active purchaser states may exclude some plans from participating
Department of Insurance	Review and approve all plans sold in exchanges in all states	• Regardless of the type of exchange, DOI will enforce federal and state regulations in fully-insured products, including non-discrimination, adherence to EHB benchmark, and network adequacy
Legislators	Pass statutory requirements for exchange plans, primarily in state-run exchange models	• Pass bills stipulating additional plan requirements in exchanges • Pass new benefit mandates, which could result in added costs to the state
Governor	Provide limited executive guidance for state-run exchanges	• May appoint board members in some state-run exchanges • Set executive policy direction for exchange decisions

What You Can Do

Build relationships with exchange board members in states operating their own exchanges.

Cultivate relationships with departments of insurance and offer them education or materials on benefit design issues, which have previously not been part of their oversight authority.

Identify targeted opportunities to use existing relationships with governors and legislatures to achieve EHB goals.

What are the policy vehicles for controlling exchange benefit design?

Advocates hoping to strengthen benefit designs have several policy vehicles available for influencing changes in the market. The top opportunities to influence benefit design at the state level include, QHP application requirements, state legislation, and state insurance regulations.

QHP Application Requirements. Most state-run exchanges issued requests for proposals for plans to sell in their exchanges. These QHP solicitation documents often include additional requirements for exchange participation. Such requirements have addressed network adequacy standards, benefit design requirements, and specific cost-sharing levels.

- *States:* For 2014, QHP applications were issued in 12 out of 15 state-run exchanges.
- *Timing:* For 2014, QHP applications were posted in late 2012 and first quarter of 2013. Moving forward, QHP applications are likely to be issued annually, so advocates may work to encourage new patient protections to be incorporated for the 2015 benefit year.

Insurance Regulations & DOI Review Process. State DOIs regulate all non-self-insured products sold in the state. As federal rules for insurers have expanded, so has the state role in enforcing those requirements. Advocates may work with DOIs to issue new regulations or institute new processes to improve enforcement and oversight of existing insurance rules. Such processes could include a series of review metrics and outlier tests to identify discriminatory plan designs.

State Legislation. State legislatures may pass bills that stipulate new requirements for exchange plans or all fully-insured products sold in the state. However, any increase in premiums associated with benefit mandates passed after 2011 could result in new costs to the state. Nonetheless, other legislation that addresses issues like maximum cost-sharing for specialty tiers but does not change overall actuarial values would not result in a charge to the state.

What You Can Do

Design creative legislative solutions that can improve patient protections without increasing state costs.

Work with the state to refine 2014 QHP applications to include stronger patient protections for target groups.

Develop tools the DOI can use to improve oversight and enforcement of existing state and federal laws for health plans.

Checklist for Engaging with States on EHB

The following checklist highlights core competencies for "patient-focused" exchanges that are well equipped to assure access to prescription medicines. Use this list to determine how your state rates against the ideal.

- ☐ Has processes in place to test for discriminatory benefit designs in QHPs
- ☐ Specifically reviews cost sharing for specialty tier medicines and verifies that most patients will be able to take a clinically appropriate medicine on a lower cost-sharing tier for most patients
- ☐ Sets requirements for the composition of the P&T committee and frequency of its meetings
- ☐ Clarifies the treatment for medical benefit therapies in EHB requirements

List of Key Decision Makers in States

The following list highlights top exchange decision makers in each state to help you target your relationship building.

State	Exchange Model	Key Decision Makers (As Of 7/22/2013)	State Benchmark Plan
Alabama	Federally-Facilitated Exchange	Jim Ridling, Insurance Commissioner Robert Turner, Insurance Rates & Forms Division Manager Kathleen Healey, Legal and Policy Advisor Richard Fiore, Executive Director of the Health Insurance Exchange	**Blue Cross Blue Shield of Alabama** PPO 320 Plan
Alaska	Federally-Facilitated Exchange	Mike Lesmann, Special Assistant to Governor Parnell Bret Kolb, Director of Division of Insurance Bill Streur, Department of Health and Social Services Commissioner	**Premera Blue Cross Blue Shield of Alaska** Heritage Select Envoy PPO
Arizona	Federally-Facilitated Exchange	Don Hughes, Healthcare Policy Advisor to the Governor Germaine Marks, Director of the Insurance Department	**United HealthCare** Arizona Benefit Options EPO Plan
Arkansas	Partnership	Cynthia Crone, Insurance Deputy Commissioner Terri Clark, Exchange Partnership Communications Specialist Chantel Allbritton, Marketplace Compliance Officer Andy Allison, Medicaid Director Jennifer Flinn, Deputy Director of Policy in Governor's Office	**HMO Partners, Inc.** Open Access POS 13262AR001
California	State-Based Exchange	Peter Lee, Executive Director of CA Health Benefit Exchange Diana Dooley, Secretary of CA Health and Human Services Agency (and Board Chair) Kimberly Belshe, Senior Policy Advisor Paul Fearer & Susan Kennedy (Board Members) Robert Ross, CEO of California Endowment	**Kaiser Foundation Health Plan, Inc.** Small Group HMO 30 ID 40513CA035
Colorado	State-Based Exchange	Patty Fontneau, Exchange Executive Director Gretchen Hammer, Executive Director / Chair of COHBE Board	**Kaiser Foundation Health Plan of Colorado** Ded HMO 1200D
Connecticut	State-Based Exchange	Kevin Counihan, Chief Executive Officer Nancy Wyman, Lt. Gov. and Chair of Exchange Board Jim Wadleigh, Chief Information Officer Julie Lyons - Director of Policy & Plan Management Virginia Lamb - General Counsel	**ConnectiCare** HMO

Delaware	Partnership	Karen Weldin Stewart, Insurance Commissioner Bettina Riveros, Advisor to the Governor, Health Care Reform	**Highmark Blue Cross Blue Shield Delaware** Simply Blue EPO 100 500
District of Columbia	State-Based Exchange	Mila Kofman, HIX Executive Director Debbie Curtis, Senior Deputy Director, Policy & Exchange Programs	**BlueCross Blue Shield CareFirst** Preferred Option 1 PPO
Florida	Federally-Facilitated Exchange	Kevin McCarty, Insurance Commissioner William Troncoso, Deputy Insurance Commissioner Cynthia Fuller, FL-OIR Policy Advisor	**Blue Cross Blue Shield of Florida, Inc.** BlueOptions PPO
Georgia	Federally-Facilitated Exchange	David Cook, Commissioner, Dept of Community Health Blake Fulenwider, Health Policy Advisor, Governor Deal	**Blue Cross Blue Shield of Georgia** HMO Urgent Care 60 Copay
Hawaii	State-Based Exchange	Coral Andrews, Executive Director of HI Health Connector Beth Giesting, Healthcare Transformation Coordinator, Governor's Office	**Hawaii Medical Service Association** Preferred Provider Plan 2010
Idaho	Supported State Based Marketplace	Amy Dowd, Executive Director of ID Health Insurance Exchange Bill Deal, Insurance Commissioner	**Blue Cross of Idaho Health Service, Inc.** Preferred Blue PPO
Illinois	Partnership	Andrew Boron, Insurance Commissioner Kate Gross, Assistant Director for Health Planning, DOI Michael Gelder, Senior Health Policy Advisor to the Governor	**Blue Cross and Blue Shield of Illinois** BlueAdvantage PPO
Indiana	Federally-Facilitated Exchange	Stephen Robertson, Insurance Commissioner	**Anthem Blue Cross and Blue Shield of Indiana** Blue 5 Blue Access PPO Medical Option 6 Rx Option G
Iowa	Plan Management Partnership	Nick Gerhart, Insurance Commissioner Michael Bousselot, Policy Advisor, Office of the Governor Sally Titus, Deputy Director, Dept of Human Services Jennifer Vermeer, Medicaid Enterprise Division Administrator	**Wellmark Inc.** Alliance Select Copayment Plus PPO
Kansas	Marketplace Plan Management	Sandy Praeger, Insurance Commissioner Linda Sheppard, Director, Accident & Health Division and PPACA Project Manager	**Blue Cross and Blue Shield of Kansas** – Comprehensive Major Medical Blue Choice PPO GF 500 deductible with Blue Rx card

Kentucky	State-Based Exchange	Sharon Clark, Insurance Commissioner Carrie Banahan, Executive Director, Cabinet for Health and Family Services/Office of Health Policy	**Anthem Health Plans of KY (Anthem BCBS)** PPO
Louisiana	Federally-Facilitated Exchange	James Donelon, Insurance Commissioner Kathy Kliebert, Secretary, Department of Health and Hospitals Crystal Marchand Campbell, Executive Director, LA Healthcare Commission (LHCC)	**Blue Cross and Blue Shield of Louisiana** GroupCare PPO
Maine	Marketplace Plan Management	Eric Cioppa, Insurance Commissioner Reinhold Bansmer, Family Independence Program Manager, DHHS / Office for Family Independence	**Anthem Health Plans of Maine** Blue Choice 20 PPO with RX 10 30 50 50
Maryland	State-Based Exchange	Therese Goldsmith, Insurance Commissioner Rebecca Pearce, Executive Director of MD Health Benefit Exchange Ben Steffen, Acting Executive Director, Maryland Health Care Commission	**CareFirst BlueChoice** HMO HSA Open Access
Massachusetts	State-Based Exchange	Joseph Murphy, Insurance Commissioner Glen Shor, Executive Director of MA Health Connector Kaitlyn Kenney, Director of Policy & Research, Commonwealth Health Insurance Connector Authority	**Blue Cross and Blue Shield of Massachusetts, Inc.** HMO Blue 2000 Deductible
Michigan	Plan Management Partnership	Kevin Clinton, Insurance Commissioner Chris Priest, Governor's advisor on all things healthcare Scott Lyon, VP of MI Small Business Association Kirk Roy, Director of BCBS of Michigan - Office of National Health Care Reform	**Priority Health** Priority HMO 100 Percent Hospital Services Plan
Minnesota	State-Based Exchange	Mike Rothman, Insurance Commissioner April Todd-Malmlov, Health Insurance Exchange Director, MN Department of Commerce	**HealthPartners** 500 25 Open Access PPO
Mississippi	Federally-Facilitated Exchange	Mike Chaney, Insurance Commissioner	**Blue Cross and Blue Shield of Mississippi** Network Blue PPO
Missouri	Federally-Facilitated Exchange	John Huff, Insurance Commissioner	**Healthy Alliance Life Insurance Co. (Anthem BCBS)** Blue 5 Blue Access PPO Medical Option 4 Rx Option D
Montana	Marketplace Plan Management	Monica Lindeen, Insurance Commissioner	**Blue Cross and Blue Shield of Montana** Blue Dimensions PPO

Nebraska	Marketplace Plan Management	Bruce Ramge, Director of Insurance John Paul Sabby, Health Policy Analyst, Insurance Department Lauren Kintner, Policy Director, Insurance Department	**Blue Cross and Blue Shield of Nebraska** BluePride PPO
Nevada	State-Based Exchange	Barbara Smith Campbell, Chair, Silver State Health Insurance Exchange Board Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy John Hager, Executive Director, Silver State Health Insurance Exchange	**Rocky Mountain Hospital & Medical Service, Inc. (Anthem BCBS)** GenRx PPO 45 Copay
New Hampshire	Partnership	Roger Sevigny, Insurance Commissioner Alexander Feldvebel, Deputy Insurance Commissioner Nicholas Toumpas, Health & Human Services Commissioner John Hunt, Co-Chair, Joint Health Care Reform Oversight Committee	**Matthew Thornton Health Plan (Anthem BCBS)** HMO Blue New England 25 50 WITH Rx 10 35 30 OOP 2500
New Jersey	Federally-Facilitated Exchange	Ken Kobylowski, Insurance Commissioner Robert Schwaneberg, Policy Advisor for Health Care, Office of the Governor	**Horizon HMO** Access HSA Compatible
New Mexico	State-based SHOP / Federally-Facilitated Indiv. Exchange	John Franchini, Superintendent of Insurance J.R. Damron, Chair, New Mexico Health Insurance Exchange Board Mike Nunez, Interim CEO, New Mexico Health Insurance Exchange	**Lovelace Insurance Company** Classic PPO
New York	State-Based Exchange	Ben Lawsky, Superintendent of Dept. of Financial Services Nirav Shah, Health Commissioner Donna Frescatore, Executive Director, NY Health Benefit Exchange	**Oxford Health Insurance, Inc.** Oxford EPO
North Carolina	Federally-Facilitated Exchange	Wayne Goodwin, Insurance Commissioner Carol Steckel, NC Medicaid Director Allen Feezor, Senior Policy Advisor, DHHS/Secretary's Office	**Blue Cross and Blue Shield of NC** Blue Options PPO
North Dakota	Federally-Facilitated Exchange	Adam Hamm, Insurance Commissioner Tami Ternes, Senior Policy Advisor-Health & Human Services, Governor's Office	**Sanford Health Plan** elite1
Ohio	Marketplace Plan Management	Mary Taylor, Lieutenant Governor, Insurance Director	**Community Insurance Company (Anthem BCBS)** Blue 6 Blue Access PPO Medical Option D4 Rx Option G
Oklahoma	Federally-Facilitated Exchange	John Doak, Insurance Commissioner Andrew Silvestri, Deputy Policy Director, Governor's Office Terry Cline, Secretary of Health & Human Services, Health Commissioner	**Blue Cross and Blue Shield of Oklahoma** BlueOptions PPO RYB05

Oregon	State-Based Exchange	Rocky King, Executive Director, Cover Oregon Liz Baxter, Chair, Cover Oregon Board of Directors Laura Cali, Insurance Commissioner	**PacificSource Health Plans** PPO Preferred CoDeduct Value 3000 35 70
Pennsylvania	Federally-Facilitated Exchange	Michael Consedine, Insurance Commissioner Franca D'Agastino, Director of Special Projects, P.I.D. Kari Kissinger, Deputy Secretary of Legislative Affairs, Governor's Office	**Aetna Health Inc.** PA POS Cost Sharing 34 1400 Ded
Rhode Island	State-Based Exchange	Kathleen Hittner, RI Insurance Commissioner Chris Koller, Health Insurance Commissioner Meg Curran, Chair of RI Exchange Board Christine Ferguson, Exchange Director Kiernan Conn, Chief Information Officer Paul McGreevy, Director of the Department of Business Regulation	**Blue Cross & Blue Shield of Rhode Island** VantageBlue PPO
South Carolina	Federally-Facilitated Exchange	Raymond Farmer, Director, SC Department of Insurance Gary Thibault, Project Manager for the Health Insurance Exchange Planning Grant Lynn Bailey, Chair of Health Insurance Exchange Workgroup	**BlueCross BlueShield of South Carolina** Business Blue Complete PPO
South Dakota	Marketplace Plan Management	Merle Schreiber, Insurance Commissioner Kea Warne, Health Insurance Exchange Project Manager, SD Office of the Governor	**Wellmark of South Dakota** Blue Select PPO
Tennessee	Federally-Facilitated Exchange	Julie "Mix" McPeak, Director of Tennessee's Insurance Exchange Planning Initiative and TN Department of Commerce and Insurance Darin Gordon, Medicaid Director Mark Cate, Chief of Staff – Governor Haslam's Office	**BlueCross BlueShield of Tennessee** PPO
Texas	Federally-Facilitated Exchange	Julia Rathgeber, State Commissioner of Insurance Rep. John Zerwas, MD (sponsor of the leading bill to create an exchange)	**Blue Cross Blue Shield of Texas** BestChoice PPO RS26
Utah	State-based SHOP / Federally-Facilitated Indiv. Exchange	Patty Conner, Director of UT Health Exchange Robert Spendlove, Deputy for State and Federal Relations Norman Thurston, Health Policy and Reform Initiative Coordinator, Utah Department of Health Todd E. Kiser, Commissioner of the Utah Insurance Department	**Public Employees Health Program (PEHP)** Utah Basic Plus
Vermont	State-Based Exchange	Susan L. Donegan, Commissioner of the Department of Financial Regulation Anya Rader Wallack, Chair of Green Mountain Care Board Lindsey Tucker, Deputy Commissioner for the Health Benefits Exchange Bram Kleppner, Danforth Pewter (Co-chair of Medicaid and Exchange Advisory Board)	**The Vermont Health Plan, LLC** CDHP-HMO

Virginia	Marketplace Plan Management	Jacqueline Cunningham, Insurance Commissioner Dr. William A. Hazel Jr., MD, Secretary of Health and Human Resources Steve Ford, Deputy Director for Administration, VA Department of Medical Assistance Services	**Anthem Health Plans of VA (Anthem BCBS)** PPO
Washington	State-Based Exchange	Mike Kreidler, Insurance Commissioner Molly Voris, Health Insurance Exchange Program Manager Nelly Kinsella, Program Specialist (HCA) Richard Onizuka, Health Benefit Exchange CEO Teresa Mosqueda, Legislative and Policy Director for the WA State Labor Council and Chair of the Healthy Washington Coalition (Healthplanfinder Policy Committee Chair)	**Regence BlueShield** Regence Innova (PPO)
West Virginia	Partnership	Mike Riley, Insurance Commissioner Jeremiah Samples, Insurance Program Manager (oversees the OIC's exchange project)	**Highmark Blue Cross Blue Shield West Virginia** Super Blue Plus 2000 1000 Ded
Wisconsin	Federally-Facilitated Exchange	Ted Nickel, Insurance Commissioner Kitty Rhoades, Secretary, WI Dept. of Health Services	**UnitedHealthcare Insurance Company** Choice Plus Definity HSA Plan A92NS
Wyoming	Federally-Facilitated Exchange	Tom C. Hirsig, Insurance Commissioner	**Blue Cross Blue Shield of Wyoming** Blue Choice Business 1000 80 20

[i] The Affordable Care Act is the combination of the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010.

[ii] Peterson, Chris, "Setting and Valuing Health Insurance Benefits," Congressional Research Service. (2009).

[iii] In most states, plans may offer a limited number of non-standardized product designs in addition to the required plan designs.