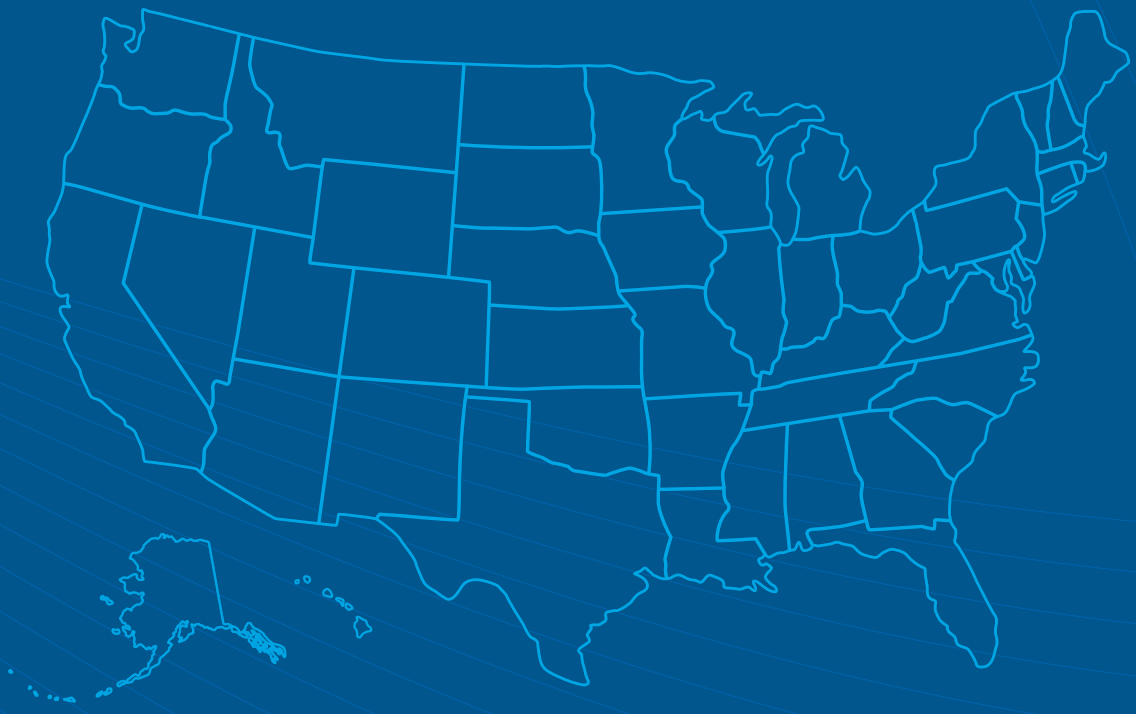
Enhancing the Patient-Centeredness of State Health Insurance Markets

State Progress Reports



PUTTING PATIENTS FIRST®
NATIONAL HEALTH COUNCIL

Founded in 1920, the NHC is the only organization that brings together all segments of the health community to provide a united and effective voice for the more than 133 million people living with chronic diseases and disabilities and their family caregivers. Made up of more than 100 national health-related organizations and businesses, its core membership includes the nation's leading patient advocacy organizations, which control its governance. Other members include professional and membership associations, nonprofit organizations with an interest in health, and major pharmaceutical, health insurance, medical device, and biotechnology companies.

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A Message for Members and Partners /

The National Health Council (NHC) and its members are committed supporters of Affordable Care Act (ACA) provisions that provide the greatest benefit to people with chronic diseases and disabilities. Since the passage of the ACA, the NHC has worked to strengthen these protections so that patients can access health insurance that meets both their health and budget needs.

As members and partners of the NHC, you and your organizations can help carry this message to state policymakers and regulators. The ACA's insurance market reforms, coverage expansions, and subsidies are significant steps forward for the patient community. However, the successful implementation of these steps relies on states to continue and even expand their role as regulators of their health insurance market. State support is critical to guaranteeing the ACA's goals of high-quality and affordable health care for all.

These state Progress Reports illustrate the variability of the patient-centeredness of health insurance markets across states. Members, partners, and the NHC will use these reports to identify states where changes could improve access to coverage and care for patients. These reports also can identify leading states that set best practices for patient-friendly requirements.

Remember, the specific reforms that are appropriate to one state may not be the right fit for all states. The goal of these reports is to encourage states to implement a range of reforms in the key areas that will have the most benefit to patients—non-discrimination, transparency, oversight, uniformity, and continuity of care.

Your actions to move these policies forward can have a lasting effect on the lives of all patients.

Background /

Exchange Operational Models

The ACA established sweeping insurance reforms that included the introduction of health insurance exchanges, where individuals and families can shop for health insurance coverage. While each state has its own exchange, the federal government plays a role in managing exchanges in many states. In general, states followed one of three paths to establish an exchange—a state-based exchange, a state-partnership exchange in which the state and federal government share exchange responsibilities, or a federally-facilitated exchange. Each model envisions a different role for states, and, as a result, the federal government. However, the federal government sets basic operating standards for all exchanges.

<table>
<tr><th></th><th>STATE-BASED EXCHANGE</th><th>STATE PARTNERSHIP EXCHANGE</th><th>FEDERALLY-FACILITATED EXCHANGE</th></tr>
<tr><td>NUMBER OF STATES</td><td>16 + DC</td><td>6</td><td>29</td></tr>
<tr><td>Plan Management</td><td rowspan="3">State</td><td rowspan="2">State</td><td rowspan="3">Federal</td></tr>
<tr><td>Consumer Assistance</td></tr>
<tr><td>Eligibility and Enrollment</td><td rowspan="2">Federal</td></tr>
<tr><td>Financial Management</td><td></td></tr>
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The Role of States

Each exchange model relies on states to ensure that plans comply with state insurance laws and to enforce some aspects of the ACA.[1] Therefore, every state has the opportunity to establish additional standards and requirements that ensure patients have access to coverage that meets their needs.

Project Purpose /

These Progress Reports aim to identify the state-by-state variation in patient friendliness of insurance exchanges to:

- Promote policies that help protect patients, and
- Discourage policies that are inconsistent with patient needs.

Methodology and Sources /

The National Health Council (NHC) works to ensure that the protections put in place by the ACA are implemented in the best interest of patients. As part of these efforts, the NHC prioritizes five key prin ciples of a truly patient-focused insurance market—non-discrimination, transparency, oversight, uniformity, and continuity-of-care.

Non-discrimination

Confirm plan designs do not discriminate or impede access to care, including a provider network that ensures patients can access care when they need it.

Transparency

Provide access to clear and accurate information for consumers about covered services and costs in exchange plans, including a user-friendly exchange website.

State oversight

Ensure all exchange plans meet applicable state and federal requirements, including the state's plan management requirements and rate review.

Uniformity

Create standards to make it easier for patients to compare exchange plans, such as a quality scorecard and standardized plan materials.

Continuity of care

Broaden sources of coverage and protect patients transitioning between plans, including expanded Medicaid.

To understand how insurance markets perform against these priorities, the reports assess each state using a set of metrics. The metrics represent specific, measurable, and actionable goals for each state's insurance market and exchange.

States are assigned scores for each metric, based on an evaluation of the state's action or market in relation to its effect on patients:

- ● Beneficial scores are assigned to states with policies or insurance market dynamics resulting in better access or choice for patients.
- ◐ Neutral scores are assigned to states without policies that result in better access or choice for patients.
- ● Negative scores are assigned to states with policies or insurance market dynamics resulting in reduced access or choice for patients.

1 Five states (Alabama, Missouri, Oklahoma, Texas, and Wyoming) have declined to play any role in oversight or enforcement of the ACA.

Then, the Progress Reports compare performance on all metrics within each principle across states, yielding state-by-state assessments for all five principles. This step determines whether states are high-performing, average-performing, or low-performing for each principle.

High-Performing Average-Performing Low-Performing

The analysis is based on a proprietary database of policy developments for all 50 states and the District of Columbia, maintained by Avalere Health. Progress Reports also reference publicly available resources, cited where applicable. The score for each metric was based on states' performance as of January 1, 2015. These reports reflect policies in effect for the 2015 exchange market and do not include proposed measures or actions. Additionally, Avalere conducted a focused review of selected topics for state exchange insurance markets, though this assessment is not intended to be a comprehensive review of all legislation and regulations pertaining to states' insurance markets.

Promising Practices across States /

While all states have taken steps to enhance the patient experience, some states have set particularly high standards for patient-centered exchange markets. In fact, the states highlighted below have implemented policies that represent models for other states considering changes to their insurance markets

Non-discrimination

Since the launch of exchanges, there has been limited federal and state action to examine plan benefits for discrimination. Currently, most states follow guidance from the federal government to ensure that exchange plan benefits are not discriminatory. Some states have enacted measures to limit opportunities for discrimination in the exchanges and to ensure patients have adequate access to services and providers.

Washington, an SBE, is a leader in fighting discrimination in the exchange market, receivingbeneficial scores across each non-discrimination metric. Specifically, Washington issued regulations that limit discrimination in exchange plans by setting increased standards for coverage and grant the insurance commissioner broad authority to reject plans with discriminatory benefits. This heightened level of authority allows the state to better protect patients from discriminatory benefits before they come to the market. Additionally, the state also took action to ensure that patients have adequate access to providers, and that under certain conditions in-network costs apply to out-of-network providers. This helps to ensure that patients receive timely and affordable treatment. Further, Washington has several platinum plan choices, giving patients with significant health needs a choice of plans with additional benefits and cost-sharing protections.

Montana, an FFE, established a new requirement to ensure that benefit designs do not discriminate or impede access to care for patients. Specifically, the state requires issuers to offer at least one silver, gold, and platinum exchange plan that uses copayments (rather than coinsurance) and that does not subject any drugs to the deductible, including the specialty tier.

State efforts to prevent, identify, and mitigate potential discrimination can make a big difference for patients with chronic conditions and disabilities, who rely on the protections afforded by the ACA.

Transparency

In states across the nation, patients have limited access to transparent, easy-to-understand, complete information about the covered services and costs of exchange plans. Most exchange websites, including HealthCare.gov, have links to plan materials, such as the formulary and provider directory. Yet, linked resources are a challenge to navigate, particularly for patients with complex conditions who need to compare the intricate details of plan coverage and costs.

In addition, some, but not all, exchanges include decision support tools, such as search tools and out-of-pocket calculators, to help patients navigate different plan choices. While most exchange websites have sort and filter functions, these features do not adequately assist patients in selecting an appropriate plan. Across the country, very few states have taken action to help increase transparency standards around covered services and costs of exchange plans. This challenges patients as they are trying to make informed plan selections.

Maryland, an SBE, is trailblazing a path for transparency standards among exchange plans. First, the state's exchange website features one decision support tool—a provider search engine – that helps patients chose a plan that includes their doctor. Additionally, the state requires plan documents to include specific information. For example, formularies must include the tier placement and cost sharing for each drug covered by the plan. Also, when issuers file their plans with the state, the documentation must include a list of medicines covered under the plan's medical benefit.

State Oversight

State oversight of exchange plans is critical to ensuring a patient-centered market. Some states enhance the oversight of the plans offered on exchanges by negotiating with carriers regarding the number of product offerings or requiring plans to offer more than silver and gold metal level plans. Other states use the rate review process to ensure that plan premiums reflect the benefits offered and that any increase in premium from year to year is justified. In most instances, well-regulated insurance markets attract a healthy number of carriers offering exchange plans, which increases competition and choice for patients. These types of measures ensure that exchange plans meet applicable requirements and that the market is competitive, allowing patients to have more options when selecting coverage.

Massachusetts, an SBE with the distinction of offering the first health insurance exchange in the country, has long acted to ensure the state has effective oversight of exchange plans. The state is considered an active purchaser, meaning the exchange negotiates with insurers, chooses which carriers can offer exchange plans, and sets criteria for participating plans. For example, Massachusetts has twelve carriers in the exchange, and each of these carriers is required to offer plans at all four metal levels, ensuring that patients have a broad set of options from which to select a plan that best meets their needs.

Michigan, an FFE, also has taken notable steps to have adequate oversight of exchange plans. The state requires issuers to standardize offerings inside and outside of the exchange, which unifies and stabilizes both markets and ensures that patients might be equally served by plans in either market.

Uniformity

States have acted to make it easier for patients to compare exchange plans. Some SBEs have standardized the benefit designs for plans at all metal levels—creating uniform cost-sharing structures for all benefits across all plans at each metal level. Six SBEs—California, Connecticut, Massachusetts, New York, Oregon, and Vermont—have standardized exchange plans in this way. Other states have taken less intensive approaches to improve plan comparisons, either by establishing plan quality rating systems or by standardizing plan materials to follow a particular template.

California, an SBE, has led other states in its efforts to improve the comparability of exchange plans. Key protections in the state include the standardized benefit designs across all metal levels, including the cost-sharing reduction versions of silver plans that are available to people with limited income. The state does not allow any non-standard plans in the exchange, which is unique among states with standardized plans. These requirements mean that all people enrolled in the same metal level plan in the state encounter the same cost sharing for the same benefits; in effect, it levels the playing field. California has implemented a quality rating system that assigns plans up to four stars using the results of consumer surveys. Finally, the state requires plans to update their formularies monthly and is developing a standard template required for plan formularies, beginning in 2017.

Continuity of Care

Actions to ensure continuity-of-care between plans or types of coverage can help patients maintain access during transition period. For example, when patients enroll in a new exchange plan for the following plan year or when eligibility for Medicaid or subsidized exchange coverage shifts, patients are at risk for problems accessing care during the change in coverage. In fact, the Medicaid expansion is itself an opportunity for states to expand coverage to low-income individuals who cannot qualify for exchange subsidies. Other states offer enhanced premium subsidies beyond assistance offered from the federal government or established bridge plans to help individuals whose income is on the border between Medicaid and subsidized exchange eligibility. Bridge plans are a type of health insurance option for people whose eligibility for Medicaid and exchange coverage might shift from year to year. Some states are creating these plans as a more stable option for patients to ensure they have consistent access to coverage and care.

Delaware, an SPE, created transition periods for people whose eligibility for public programs changes, including those moving from Medicaid into exchange plans. The requirements allow people to access prescriptions for 60 days and medical treatments for 90 days to ensure patients can maintain their treatment plans while changing plans or sources of coverage.

Vermont, an SBE, funds cost-sharing reduction subsidies for a larger group of exchange enrollees than the federally funded program. The expanded population includes individuals and families with income between 250% and 300% of the federal poverty level, expanding the population of people who are eligible for this extra financial assistance in the state.

Areas for Actions /

Following the first full year of exchanges, some states have emerged as leaders in implementing patient-centered standards and reforms. However, there is more work left to do.

Given the challenges leading up to exchange implementation and the Medicaid expansion, some states prioritized operational and technical readiness over patient-friendly tools and standards. Now that HealthCare.gov and most SBE websites are operating effectively, it is important for states to begin to turn their attention to ensuring that all people have access to coverage and care that meets their needs.

Opportunities exist for patient advocates to work with states to improve the patient-friendliness of their insurance markets in the coming years. NHC partners may consider the following three issues as they develop their advocacy plans for the 2016 and 2017 plan years.

State and Federal Considerations /

These reports identify states creating some of the nation's most patient-friendly insurance markets as leaders that can help to pave the way for other states. At the same time, they also uncover some key areas for improvement to make the exchanges truly patient centered. Together with advocacy groups and aligned partners, states can use their performance across the metrics as starting points to begin to move exchange markets in favor of helping patients access better and more affordable care. Throughout the course of advocacy efforts, one must be mindful of the following points:

Understand the State Audience

Advocates can leverage their insight into the state's dynamic to target the right audience with the applicable message at the appropriate time. Some of the metrics identified in these reports represent approaches to insurance markets on which both sides of the political spectrum can agree (i.e. transparency). These types of less contentious, bipartisan policies are good starting points for some states looking to secure new protections for patients. Other states with a more active legislative or regulatory history on exchanges might be good targets for more complex patient-centered measures, such as standardized benefit designs, supplemental premium subsidies, or cost-sharing caps.

Consider the Federal Government

Members and partners also should consider the role the federal government plays to establish standards for many of these priority areas. Current federal standards are quite limited in their patient centeredness, offering significant opportunity to make adjustments that would lead to enhanced patient protections for many, or even all, states. With so many states using HealthCare.gov and following other federal standards, national requirements may offer substantial influence over markets across multiple states in the near term.

Moving Forward /

The National Health Council is dedicated to ensuring that the ACA achieves its objectives of high quality and affordable care for all people, including those with chronic diseases and disabilities. Understanding the landscape of patient-centeredness across all states can begin conversations that lead to positive changes for patients in these markets. The NHC will continue to work with members and partners as they engage with states and the federal government to ensure the exchange markets offer the most equitable, affordable, and highest quality coverage and care possible for patients.

Increase State Oversight and Regulation of Exchange Markets

Currently, most states rely upon limited federal guidance for the methods they should use to ensure that exchange markets are not discriminatory. Few states have taken steps to further define their plan reviews and oversight activities. Most SBEs are not actively negotiating with plans to participate in the exchange. And, though most states have an effective rate review process, additional standards in this area can further influence premium rates among exchange plans. Finally, most SBEs have not set contracting standards for participation in the exchange, such as requiring that the issuers offer plans across all metal levels. These types of oversight actions can help to ensure that patients can access appropriate and affordable choices in the exchanges.

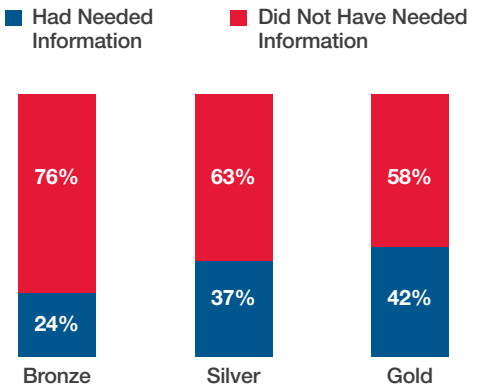
Support Implementation of Robust Quality Rating Systems in All Exchanges

The SBEs of Connecticut, Hawaii, Idaho, Kentucky, and Vermont have not yet released information about their quality rating systems. SBEs have the option to implement their own standards by 2017 or to follow the federal approach. For FFEs, public reporting of quality ratings and enrollee satisfaction will occur for the 2017 open enrollment period. NHC partners have the opportunity to work with states and the federal government to encourage rating systems that measure the experience of patients in plans and also appropriately reward plans for focusing on patient-centered care.

Ensure Medicaid Changes and Expansions Offer Protections Afforded under the Traditional Program

A state's approach to Medicaid expansion should ensure that patients have increased access to coverage and care, while preserving the patient protections guaranteed under the program. In 21 states, Medicaid has not been expanded to individuals and families with incomes below 138% of the federal poverty level, leaving many patients without any access to affordable health coverage. Another six states used waivers to allow the state to enroll eligible individuals and families into exchange plans rather than traditional Medicaid. Though these waivers do expand access to coverage, advocates and states should work together to ensure that Medicaid enrollees in these states have the full protections afforded under traditional Medicaid.

Figure 1. Share of Respondents Who Reported Having "All the Information They Needed" When Choosing a Health Plan



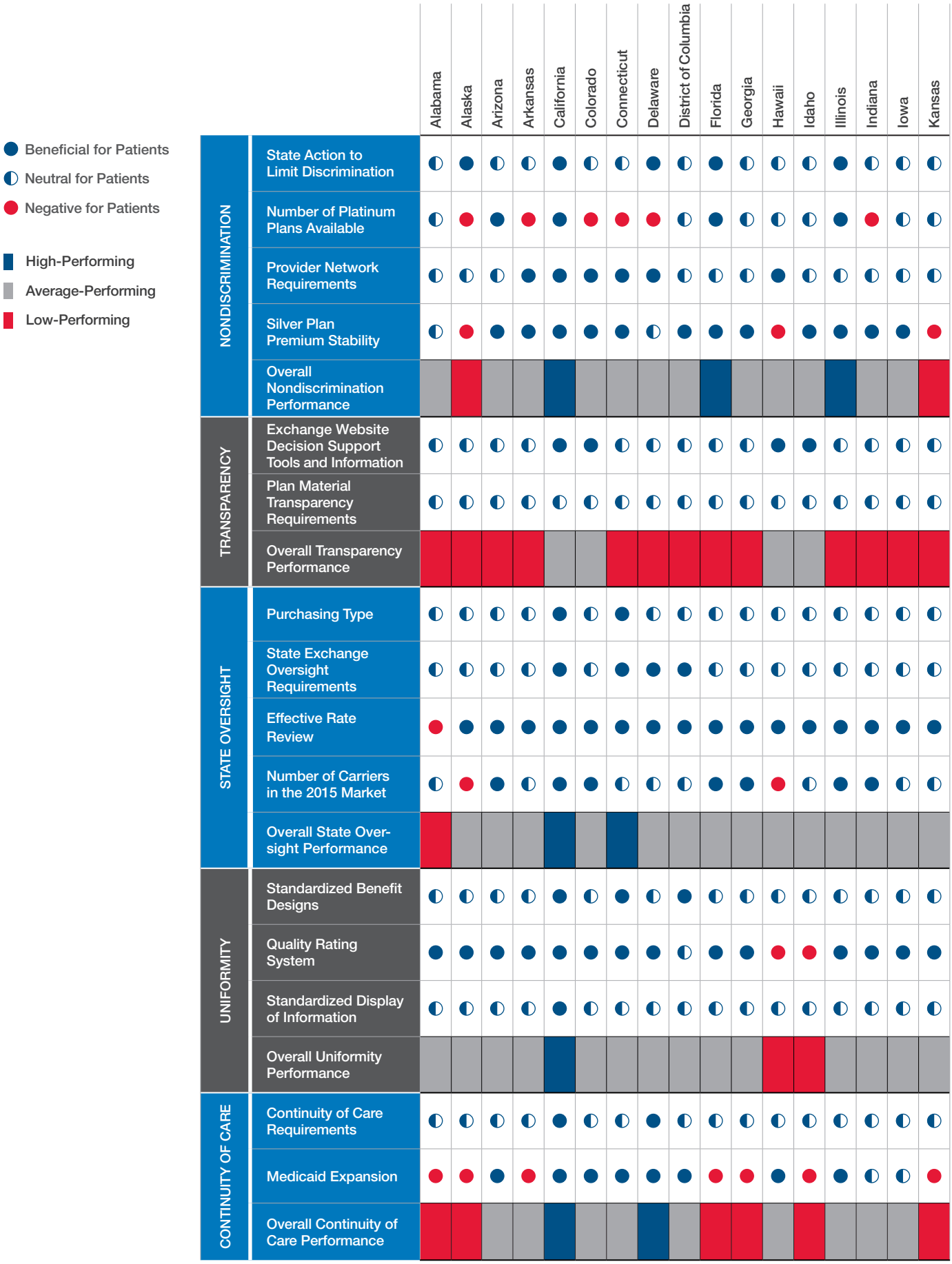
Advance Patient Tools that Improve Transparency

Tools that increase transparency into the coverage and costs of exchange plans or offer decision support mechanisms can improve the plan selection process for people shopping for coverage in exchange plans. The cost to develop effective decision support tools may be prohibitive to many SBEs, and some states may to need to rely on federal tools, when and if they are developed.

A more attainable option for many states might be requirements that improve the transparency of plan information. The NHC's recent survey indicated that most patients felt they did not have all the information they needed to choose a health plan. Further, 36% of exchange enrollees had a hard time finding a list of providers and 38% had difficulty accessing plan formularies.[2] Even without large-scale, decision support tools, states can make small improvements to transparency standards that go a long way to helping people enroll in plans that meet their health and budget needs.

2 Navigating the ACA among Enrollees with Chronic Illnesses," Celinda Lake, March 2015.

State-by-State
Patient-Centeredness Data


Beneficial for Patients
Neutral for Patients
Negative for Patients
High-Performing
Average-Performing
Low-Performing
Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
NONDISCRIMINATION
State Action to Limit Discrimination
Number of Platinum Plans Available
Provider Network Requirements
Silver Plan Premium Stability
Overall Nondiscrimination Performance
TRANSPARENCY
Exchange Website Decision Support Tools and Information
Plan Material Transparency Requirements
Overall Transparency Performance
STATE OVERSIGHT
Purchasing Type
State Exchange Oversight Requirements
Effective Rate Review
Number of Carriers in the 2015 Market
Overall State Oversight Performance
UNIFORMITY
Standardized Benefit Designs
Quality Rating System
Standardized Display of Information
Overall Uniformity Performance
CONTINUITY OF CARE
Continuity of Care Requirements
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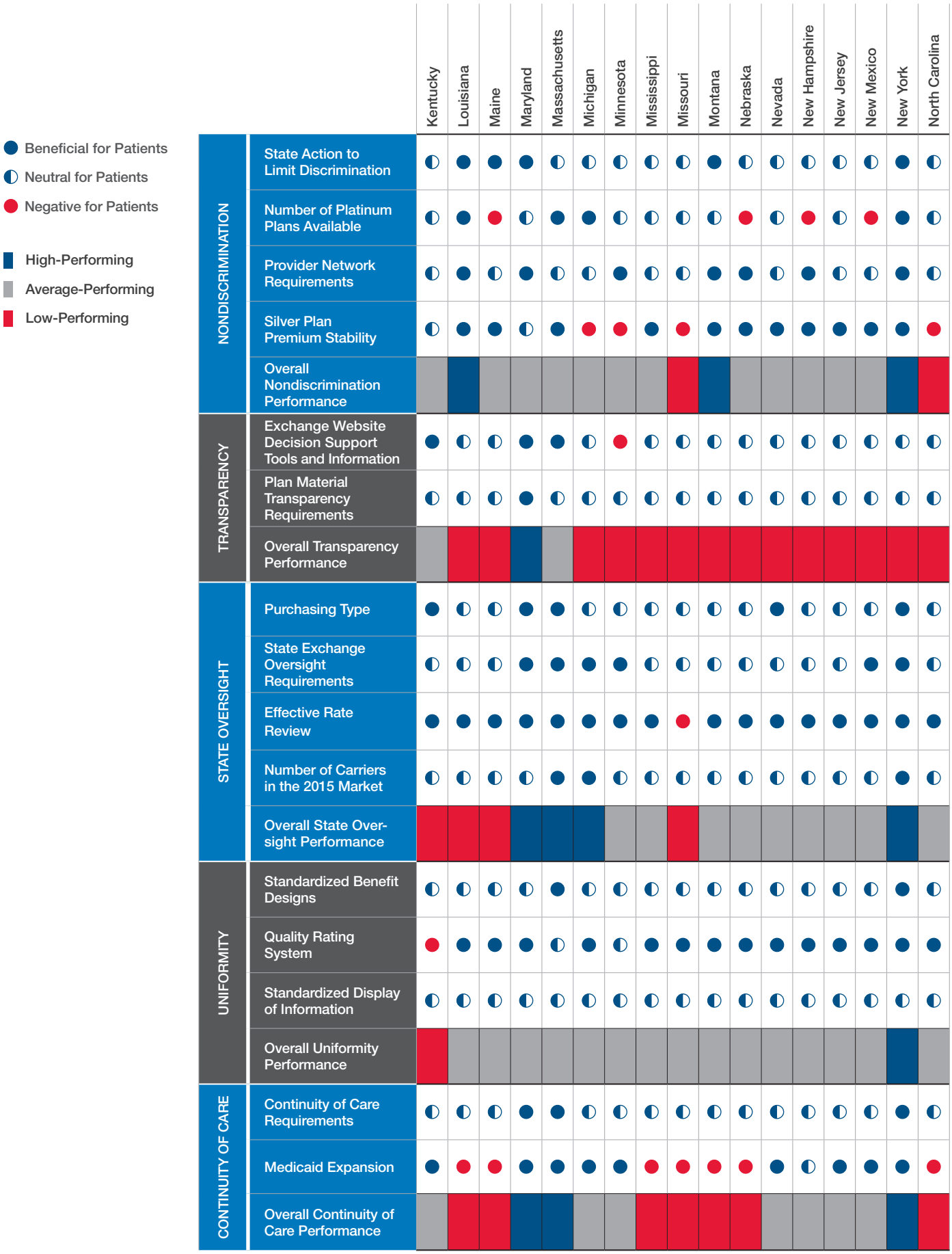
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New Jersey
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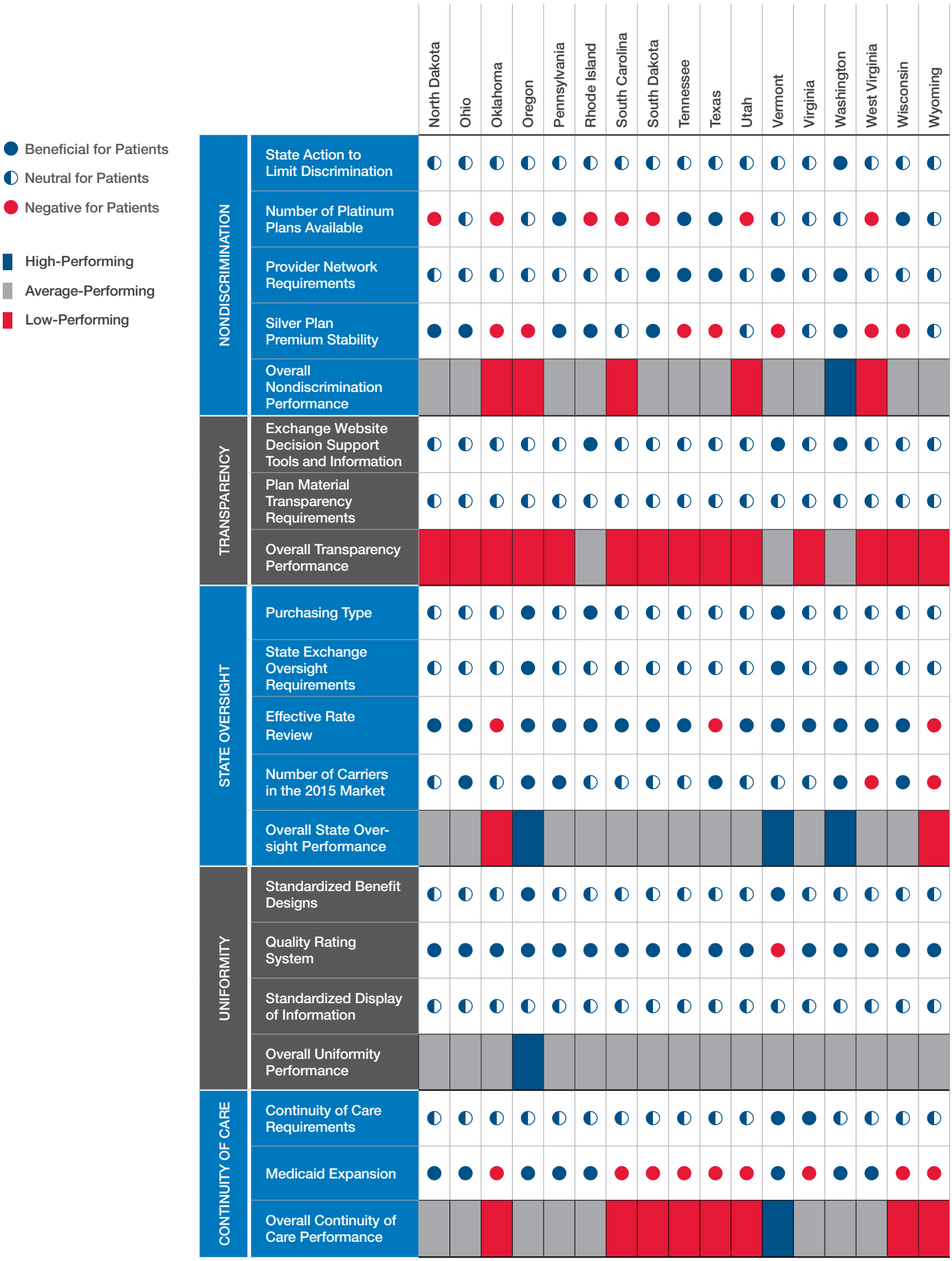
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Utah
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Washington
West Virginia
Wisconsin
Wyoming
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State-by-State
Progress Reports

State Actions Protecting Patients in the Exchange

Alabama Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Four unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Alabama is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Alabama is a

Low-Performing State

ALABAMA HIGHLIGHTS

Alabama's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 97,900 Alabamians selected an exchange plan through HealthCare.gov. About 22% of Alabama residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Alabama has not expanded Medicaid.

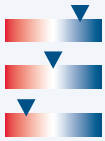
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Alabama does not have an effective rate review program.[3]
- Three carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Alabama is a

Low-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Alabama is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Alabama has not expanded Medicaid, which would provide coverage for an estimated 272,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Alabama is a

Low-Performing State

A MORE PATIENT-FOCUSED ALABAMA MARKETPLACE

Alabama has not exercised its full authority to regulate the exchange to promote patient protections. Alabama's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Alabama would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Alabama has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Alabama also could become an active purchaser, which could help the state better manage increasing premiums.

Another critical step towards a patient-friendly health insurance market would be for Alabama to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 272,000 Alabamians.

METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Alaska Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- Alaska enacted legislation requiring issuers to notify members at least 90 days before implementing cost sharing, deductibles, and copayments for certain categories of drugs (e.g., specialty medications) that exceed those for non-preferred brand drugs.
- Alaska has no platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 28% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Alaska is a

Low-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Alaska is a

Low-Performing State

ALASKA HIGHLIGHTS

Alaska's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 12,900 Alaskans selected an exchange plan through HealthCare.gov. About 15% of Alaska residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Alaska has not expanded Medicaid.

PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Two carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Alaska is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Alaska is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Alaska has not expanded Medicaid, which would provide coverage for an estimated 30,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Alaska is a

Low-Performing State

A MORE PATIENT-FOCUSED ALASKA MARKETPLACE

Alaska has not exercised its full authority to regulate the exchange to promote patient protections. Alaska's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Alaska would have more control over exchange plans if the state opted to create a state-based exchange or a partnership exchange. Alaska has yet to establish exchange standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements. In addition, Alaska's exchange does not foster competition as there are only two carriers offering coverage. As a result, there are no platinum plans offered in the state, limiting options for the people who would benefit most—those with chronic conditions and disabilities. Under a different operational model, Alaska also could become an active purchaser, which could help the state better manage increasing premiums. Another critical step towards a patient-friendly health insurance market would be for Alaska to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 30,000 Alaskans.

METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Arizona Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ● Seventeen unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 10% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Arizona is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Arizona is a

Low-Performing State

ARIZONA HIGHLIGHTS

Arizona's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 120,100 Arizonans selected an exchange plan through HealthCare.gov. About 19% of Arizona residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Arizona expanded Medicaid, effective January 1, 2014.

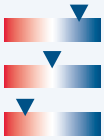
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Eleven carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Arizona is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Arizona is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Arizona expanded Medicaid, which now covers an estimated 299,000 people in the state.

For continutity-of-care metrics, relative to other states, Arizona is an

Average-Performing State

A MORE PATIENT-FOCUSED ARIZONA MARKETPLACE

Arizona has not exercised its full authority to regulate the exchange to promote patient protections. Arizona's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Arizona would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Arizona has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Arizona also could become an active purchaser.

METHODOLOGY

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1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

Arkansas Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- No unique platinum offerings in the 2015 exchange.
- Arkansas enacted legislation requiring exchange plans to meet specified minimum network adequacy standards for primary care doctors, essential community providers, and specialists.
- The premium for the 2nd lowest cost silver plan is 2% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Arkansas is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Arkansas is a

Low-Performing State

ARKANSAS HIGHLIGHTS

Arkansas established a state-federal partnership exchange. The state is responsible for managing plan participation and customer assistance in the exchange. Arkansas residents use the federal exchange, HealthCare.gov, to compare and purchase coverage.

In the 2014 plan year, 43,400 Arkansans selected an exchange plan through HealthCare.gov. About 17% of Arkansas residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Arkansas expanded Medicaid, effective in 2014.

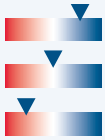
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Four carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Arkansas is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Arkansas is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Arkansas has expanded Medicaid under a premium assistance model, which now covers an estimated 75,000 people in the state.

For continuity-of-care metrics, relative to other states, Arkansas is an

Average-Performing State

A MORE PATIENT-FOCUSED ARKANSAS MARKETPLACE

Arkansas' partial reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Arkansas would have more control over exchange plans if the state opted to create a state-based exchange; currently, the state intends to run its own SHOP exchange in 2016 and its individual exchange in 2017.[5] Arkansas has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Arkansas also could become an active purchaser to have more authority over plan participation. Further, the state has no platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan. As Arkansas implements the premium assistance model, the state should ensure the model preserves patient protections inherent in Medicaid.

METHODOLOGY

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1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 The Governor signed legislation delaying the state's plans to establish a state-based exchange until the Supreme Court rules on the legality of subsidies in federally-facilitated exchanges.

California Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- California prohibits issuers from altering product benefit design from copayment to coinsurance or vice versa, or shifting product types (e.g., PPO, HMO).
- Sixteen unique platinum plans in the 2015 exchange.
- California enacted legislation increasing provider network adequacy and timely access to care, and prohibited plans from narrowing networks beyond normal network churn.
- The premium for the 2nd lowest cost silver plan is 1% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, California is a

High-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- California's website offers a cost calculator to help consumers estimate their annual medical spending for each plan offering. The enrollment portal allows consumers to filter plan options and has links to plans' provider directories and formularies. However, the website lacks formulary and provider search tools.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, California is an

Average-Performing State

CALIFORNIA HIGHLIGHTS

California established a state-based exchange, called Covered California.

In the 2014 plan year, 1.2 million Californians selected an exchange plan through Covered California. About 37% of California residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

California expanded Medicaid, effective January 1, 2014.

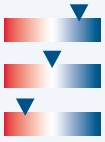
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- California requires multi-year contracts, limits the number of bids submitted by issuers, and requires plans to offer products in specific metals levels, including catastrophic plans.
- Its effective rate review program allows the state to manage premium increases.[3]
- Eleven carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, California is a

High-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- California standardized benefit designs.
- California rates exchange plans using a four-star quality rating system, derived from consumer survey results.
- California requires issuers to provide formularies online and update the information monthly. The state is developing a standard formulary template that will be implemented by January 1, 2017.

For uniformity metrics, relative to other states, California is a

High-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- California is awaiting approval to implement Bridge Plans, which aim to reduce the effects of churn between Medicaid and the exchange. The state also requires managed care plans to allow enrollees to continue seeing providers who have left their plan's network per the enrollee's request, for select conditions or services in a specific time frame.[4]
- California expanded Medicaid, which now covers an estimated 2,343,000 people in the state.

For continuity-of-care metrics, relative to other states, California is a

High-Performing State

A MORE PATIENT-FOCUSED CALIFORNIA MARKETPLACE

California has achieved considerable success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients.

However, California has not exercised its full authority to regulate the exchange to promote patient protections. Notably, the state could enact contracting requirements to enhance plan information transparency. Though Covered California has an out-of-pocket calculator, it is limited in its ability to accurately assess estimated costs for patients. In order to best protect patients, California should develop a more robust and precise tool.

METHODOLOGY

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

Colorado Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Two unique platinum plans in the 2015 exchange.
- Colorado mandates that managed care plans have a provider network that is sufficient in numbers and types of providers to ensure timely access to care.
- The premium for the 2nd lowest cost silver plan is 16% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Colorado is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Colorado's website has a formulary search tool to show whether each available plan covers specific drugs. The site has a provider search tool, a calculator to estimate tax credit amounts, access to plans' provider directories and formularies, as well as filters for search results.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Colorado is an

Average-Performing State

COLORADO HIGHLIGHTS

Colorado established a state-based exchange, called Connect for Health Colorado.

In the 2014 plan year, 146,100 Coloradans selected an exchange plan through Connect for Health Colorado. About 25% of Colorado residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Colorado expanded Medicaid effective January 1, 2014.

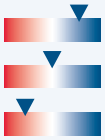
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Twelve carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Colorado is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Colorado rates exchange plans using a five-star quality score based customer surveys as well as clinical measures.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Colorado is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Colorado expanded Medicaid, which now covers an estimated 351,000 people in the state.

For continutity-of-care metrics, relative to other states, Colorado is an

Average-Performing State

A MORE PATIENT-FOCUSED COLORADO MARKETPLACE

Colorado has achieved considerable success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients.

However, Colorado has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Colorado could standardize benefit designs and plan benefit materials. The state also could consider oversight activities that would screen exchange plans for discrimination. The state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan. Since it is a state-based exchange, Colorado could exert even more influence over the exchange by becoming an active purchaser.

METHODOLOGY

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

Connecticut Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum plan in the 2015 exchange.
- Connecticut requires exchange plans to have a provider network that is sufficient in numbers to ensure timely access to care.
- The premium for the 2nd lowest cost silver plan is 5% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Connecticut is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- The website allows consumers to filter plan offerings and has links to provider directories and formularies. The website lacks formulary and provider search tools and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Connecticut is a

Low-Performing State

CONNECTICUT HIGHLIGHTS

Connecticut established a state-based exchange, called Access Health CT.

In the 2014 plan year, 74,300 Connecticut residents selected an exchange plan through Access Health CT. About 33% of Connecticut residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Connecticut expanded Medicaid, effective January 1, 2014.

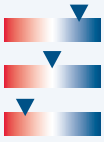
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- Connecticut requires multi-year contracts, limits the number of bids submitted by issuers, requires plans to offer products in specific metals levels, and requires plans by a single issuer to have distinct differences.
- Its effective rate review program allows the state to manage premium increases.[3]
- Six carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Connecticut is a

High-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- Connecticut standardized benefit designs.
- Connecticut rates exchange plans using a four-star quality rating system based on measures from the National Committee for Quality Assurance.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Connecticut is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Connecticut expanded Medicaid.

For continuity-of-care metrics, relative to other states, Michigan is an

Average-Performing State

A MORE PATIENT-FOCUSED CONNECTICUT MARKETPLACE

Connecticut has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Connecticut has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Connecticut could standardize plan benefit materials and enhance transparency of plan documents. Patients would also benefit from the development of an out-of-pocket calculator to estimate health expenses and better inform plan selection.

The state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Additional contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Finally, Connecticut could take actions to establish continuity-of-care requirements to help patients maintain access to care.

METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

Delaware Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- Delaware enacted legislation capping patient cost sharing for specialty tier drugs. The legislation also prohibits issuers from placing all drugs in a given class of drugs on a specialty tier.
- One unique platinum plan in the 2015 exchange.
- Delaware mandates that all plans sold in the exchange must have at least one full-time equivalent primary care provider for every 2,000 patients.
- The premium for the 2nd lowest cost silver plan is 4% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Delaware is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Delaware is a

Low-Performing State

DELAWARE HIGHLIGHTS

Delaware established a state-federal partnership exchange. The state is responsible for managing plan participation and customer assistance in the exchange. Delaware residents use the federal exchange, HealthCare.gov, to compare and purchase coverage.

In the 2014 plan year, 14,100 Delawareans selected an exchange plan through HealthCare.gov. About 29% of Delaware residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Delaware expanded Medicaid, effective in 2014.

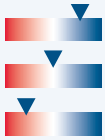
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- Delaware requires plans to offer products in specific metals levels, including bronze plans.
- Its effective rate review program allows the state to manage premium increases.[3]
- Three carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Delaware is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Delaware is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- Health plans in 2015 must have transition policies in place for individuals who become eligible or lose eligibility for public programs, including those transitioning into exchange health plans from Medicaid. Policies must include a 60-day transition period for prescriptions, and a 90-day transition period for medical conditions and pre-authorized treatments.
- Delaware expanded Medicaid, which now covers an estimated 12,000 people in the state.

For continuity-of-care metrics, relative to other states, Delaware is a

High-Performing State

A MORE PATIENT-FOCUSED DELAWARE MARKETPLACE

Delaware's partial reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Delaware would have more control over exchange plans if the state opted to create a state-based exchange. Delaware has yet to establish standards that would increase transparency or uniformity and protect patients from discrimination. The state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan. Additionally, under a different operational model, Delaware could also become an active purchaser to have more authority over plan participation and better manage increasing premiums.

METHODOLOGY

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

District of Columbia Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Three unique platinum offerings in the 2015 exchange.
- ◐ No action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is less than 1% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, DC is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ DC's website allows consumers to filter plan options and has links to plans' provider directories. However, the website lacks links to plans' formularies, formulary and provider search tools, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, DC is a

Low-Performing State

DC HIGHLIGHTS

DC established a state-based exchange, called DC Health Link.

In the 2014 plan year, 19,500 DC residents selected an exchange plan through DC Health Link. About 59% of DC residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

DC expanded Medicaid, effective in 2014.

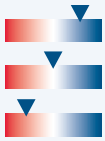
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the district does not actively negotiate with plans to participate in the exchange.
- DC requires plans to offer products in specific metal levels, including bronze plans, and ties participation outside and inside of the exchange.
- Its effective rate review program allows the state to manage premium increases.[3]
- Four carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, DC is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- DC will require standardized benefit designs beginning in 2016.
- DC expressed interest in developing quality reporting requirements for the 2016 plan year.
- No action on standardized display of plan information.

For uniformity metrics, relative to other states, DC is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No action on continuity-of-care requirements.[4]
- DC expanded Medicaid, which now covers an estimated 20,000 people in the state.

For continuity-of-care metrics, relative to other states, DC is an

Average-Performing State

A MORE PATIENT-FOCUSED DC MARKETPLACE

DC has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, DC has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other action, DC could improve plan information transparency or standardize plan benefit materials. Patients would benefit from the development of quality rating measures to better inform plan selection and oversight activities that would screen exchange plans for discriminatory benefits. As a state-based exchange, DC could exert even more influence over the exchange by becoming an active purchaser. DC could also consider instituting continuity-of-care requirements to ensure that patients have stable access to care. Furthermore, DC's exchange website should include links to formularies, and tools such as formulary and provider search tools.

METHODOLOGY

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

Florida Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- In 2014, Florida enacted legislation to prohibit unfair methods of competition or deceptive acts to advertise insurance policies. Plans may not misrepresent the benefits, conditions, or terms of any insurance policy.
- Twenty-eight unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 2% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Florida is a

High-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Florida is a

Low-Performing State

FLORIDA HIGHLIGHTS

Florida's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 983,800 Floridians selected an exchange plan through HealthCare.gov. About 39% of Florida residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Florida has not expanded Medicaid.

PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Twelve carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Florida is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Florida is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Florida has not expanded Medicaid, which would provide coverage for an estimated 1,212,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Florida is a

Low-Performing State

A MORE PATIENT-FOCUSED FLORIDA MARKETPLACE

Florida's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Florida would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Florida has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Florida also could become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for Florida to expand Medicaid. The state legislature has debated the issue but never approved it. Expansion of Medicaid would provide health insurance for nearly 1.2 million Floridians.

METHODOLOGY

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5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Georgia Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Seven unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 2% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Georgia is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Georgia is a

Low-Performing State

GEORGIA HIGHLIGHTS

Georgia's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 316,500 Georgians selected an exchange plan through HealthCare.gov. About 29% of Georgia residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Georgia has not expanded Medicaid.

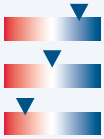
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Ten carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Georgia is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Georgia is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Georgia has not expanded Medicaid, which would provide coverage for an estimated 599,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Georgia is a

Low-Performing State

A MORE PATIENT-FOCUSED GEORGIA MARKETPLACE

Georgia's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Georgia would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Georgia has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Georgia also could become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for Georgia to expand Medicaid. Expansion of Medicaid would provide health insurance for nearly 600,000 Georgians.

METHODOLOGY

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Hawaii Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Four unique platinum offerings in the 2015 exchange.
- Hawaii enacted legislation requiring the Insurance Commissioner to provide the Hawaii Health Connector with a list of qualified health plans that meet network adequacy standards (as determined by the Commissioner).
- The premium for the 2nd lowest cost silver plan is 9% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Hawaii is an

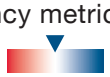
Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Hawaii's website offers a provider search tool, and allows consumers to filter plan options. Additionally, the website has links to plans' provider directories and formularies. However, the website lacks a formulary search tool and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Hawaii is an



Average-Performing State

HAWAII HIGHLIGHTS

Hawaii established a state-based exchange, called the Hawaii Health Connector.

In the 2014 plan year, 9,700 Hawaiians selected an exchange plan through Hawaii Health Connector. About 18% of Hawaii residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Hawaii expanded Medicaid, effective January 1, 2014.

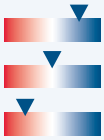
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Two carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Hawaii is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Hawaii does not currently have a quality rating system in place for the 2015 plan year, and there are no details available on plans to develop a quality rating system.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Hawaii is a

Low-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Hawaii expanded Medicaid, which now covers an estimated 10,000 people in the state.

For continutity-of-care metrics, relative to other states, Hawaii is an

Average-Performing State

A MORE PATIENT-FOCUSED HAWAII MARKETPLACE

Hawaii has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Hawaii has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Hawaii could standardize plan benefit materials and enhance transparency of plan documents. Patients would also benefit from the development of quality rating measures as well as an out-of-pocket calculator to estimate health expenses and better inform plan selection. In addition, Hawaii's exchange does not foster competition as there are only two carriers offering coverage. As a result of the lack of competition, there are few platinum plans offered in the state, limiting options for the people who would benefit most—those with chronic conditions and disabilities. Furthermore, Hawaii could take actions to establish continuity-of-care requirements to help patients maintain access to care.

METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

Idaho Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Three unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 9% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Idaho is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ● Idaho's website allows consumers to filter plan options, and has links to plans' provider directories and formularies. The website also has a calculator to help patients estimate out-of-pocket spending amounts. However, the website lacks formulary and provider search tools.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Idaho is an

Average-Performing State

IDAHO HIGHLIGHTS

For 2015, Idaho established a state-based exchange, called Your Health Idaho. In 2014, Idaho operated as a state-run exchange using the HealthCare.gov platform.

In the 2014 plan year, 76,100 Idahoans selected an exchange plan through HealthCare.gov. About 35% of Idaho residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Idaho has not expanded Medicaid.

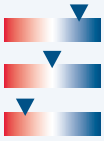
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Five carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Idaho is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Idaho does not currently have a quality rating system in place for the 2015 plan year, and there are no details available on plans to develop a quality rating system.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Idaho is a

Low-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Idaho has not expanded Medicaid, which would provide coverage for an estimated 86,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Idaho is a

Low-Performing State

A MORE PATIENT-FOCUSED IDAHO MARKETPLACE

Idaho has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Idaho has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Idaho could standardize plan benefit materials, and enhance transparency of plan documents. Idaho should also work to develop tools for patients to use on the website that increase transparency to better inform plan selection. Idaho also could take actions to establish continuity-of-care requirements to help patients maintain access to care. Another critical step towards a patient-friendly health insurance market would be for Idaho to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 86,000 Idahoans.

METHODOLOGY

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Illinois Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- The Illinois Department of Insurance (DOI) created non–discrimination polices to protect people with HIV/AIDS. Issuers must cover all HIV/AIDS medicines the government considers "recommended" or "alternative" drug regimens. Issuers also cannot impose unreasonable step therapy requirements to recommended or alternative regimens designated by the government.
- Seventeen unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 2% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Illinois is a

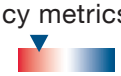
High-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Illinois is a



Low-Performing State

ILLINOIS HIGHLIGHTS

Illinois established a state-federal partnership exchange. Illinois manages plan participation, customer assistance, and operates the consumer assistance web-portal Get Covered Illinois. Illinois residents must use the federal exchange, HealthCare.gov, to enroll in coverage.

In the 2014 plan year, 217,500 Illinoisans selected an exchange plan through HealthCare.gov. About 23% of Illinois residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Illinois expanded Medicaid, effective January 1, 2014.

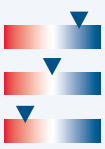
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contraction requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Eleven carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Illinois is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Illinois is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Illinois has expanded Medicaid, which now covers an estimated 418,000 people in the state.

For continutity-of-care metrics, relative to other states, Illinois is an

Average-Performing State

A MORE PATIENT-FOCUSED ILLINOIS MARKETPLACE

Illinois has achieved some success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients. However, Illinois's partial reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Illinois would have more control over exchange plans if the state opted to create a state-based exchange. Illinois has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination that encompasses more conditions than just HIV/AIDS, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Illinois also could become an active purchaser to better manage exchange plan participation.

METHODOLOGY

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

Indiana Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum offering in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 7% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Indiana is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Indiana is a

Low-Performing State

INDIANA HIGHLIGHTS

Indiana's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 132,400 Hoosiers selected an exchange plan through HealthCare.gov. About 26% of Indiana residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Indiana expanded Medicaid, effective February 1, 2015.

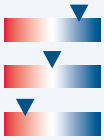
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Ten carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Indiana is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Indiana is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Indiana expanded Medicaid via a waiver model that requires some beneficaires to make monthly contributions. The program covers an estimated 79,000 people in the state.

For continutity-of-care metrics, relative to other states, Indiana is an

Average-Performing State

A MORE PATIENT-FOCUSED INDIANA MARKETPLACE

Indiana has not exercised its full authority to regulate the exchange to promote patient protections. Indiana's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Indiana would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Indiana has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. In addition, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Under a different operational model, Indiana also could become an active purchaser. As Indiana implements the waiver program, the state should ensure the program preserves patient protections inherent in Medicaid.

METHODOLOGY

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

Iowa Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Three unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 4% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Iowa is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Iowa is a

Low-Performing State

IOWA HIGHLIGHTS

Iowa established a state-federal partnership exchange. The state is responsible for managing plan participation and customer assistance in the exchange. Iowa residents use the federal exchange, Healthcare.gov, to compare and purchase coverage.

In the 2014 plan year, 29,200 Iowans selected an exchange plan through Healthcare.gov. About 13% of Iowa residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Iowa expanded Medicaid effective January 1, 2014. Iowa did not expand the traditional Medicaid program but used a waiver to enroll most newly eligible beneficiaries in the exchange and provide assistance paying monthly premiums.

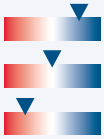
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

NATIONAL HEALTH COUNCIL

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Three carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Iowa is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Iowa is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Iowa has expanded Medicaid under a premium assistance model, which now covers an estimated 75,000 people in the state.

For continutity-of-care metrics, relative to other states, Iowa is an

Average-Performing State

A MORE PATIENT-FOCUSED IOWA MARKETPLACE

Iowa's partial reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Iowa would have more control over exchange plans if the state opted to create a state-based exchange. Iowa has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Iowa also could become an active purchaser to have more authority over plan participation. As Iowa implements the premium assistance model, the state should ensure the model preserves patient protections inherent in Medicaid.

METHODOLOGY

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Kansas Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Two unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 10% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Kansas is a

Low-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Kansas is a

Low-Performing State

KANSAS HIGHLIGHTS

Kansas's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 57,000 Kansans selected an exchange plan through HealthCare.gov. About 23% of Kansas residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Kansas has not expanded Medicaid.

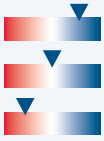
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Four carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Kansas is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Kansas is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements. [4]
- Kansas has not expanded Medicaid, which would provide coverage for an estimated 126,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Kansas is a

Low-Performing State

A MORE PATIENT-FOCUSED KANSAS MARKETPLACE

Kansas has not exercised its full authority to regulate the exchange to promote patient protections. Kansas' reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Kansas would have more control over exchange plans if the state opted to create a state-based exchange. Kansas has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements. Under a different operational model, Kansas also could become an active purchaser, which could help the state better manage increasing premiums. In addition, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Another critical step towards a patient-friendly health insurance market would be for Kansas to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 126,000 Kansans.

METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Kentucky Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Two unique platinum plans in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Kentucky is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Kentucky's website has a provider search tool, a calculator to estimate tax credit amounts, links to plans' provider directories and formularies, and allows consumers to filter plan options. The website lacks a formulary search tool.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Kentucky is an

Average-Performing State

KENTUCKY HIGHLIGHTS

Kentucky established a state-based exchange, called Kynect.

In the 2014 plan year, 83,000 Kentuckians selected an exchange plan through Kynect. About 32% of Kentucky residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Kentucky expanded Medicaid, effective in 2014.

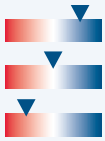
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Eight carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Kentucky is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Kentucky does not currently have a quality rating system in place for the 2015 plan year, and there are no details available on plans to develop a quality rating system.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Kentucky is a

Low-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Kentucky expanded Medicaid, which now covers an estimated 467,000 people in the state.

For continuity-of-care metrics, relative to other states, Kentucky is an

Average-Performing State

A MORE PATIENT-FOCUSED KENTUCKY MARKETPLACE

Kentucky has achieved considerable success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients.

However, Kentucky has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Kentucky could standardize benefit designs or plan benefit materials, as well as require more robust provider networks. Patients would benefit from the development of quality rating measures to better inform plan selection. The state also could consider oversight activities that would screen exchange plans for discrimination and enhance transparency of plan documents. Additionally, there are few platinum plans offered in the state, limiting options for the people who would benefit most—those with chronic conditions and disabilities. Furthermore, Kentucky could take actions to establish continuity-of-care requirements to help patients maintain access to care.

METHODOLOGY

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1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

Louisiana Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- Louisiana enacted legislation capping patient cost sharing at $150 per month for specialty tier drugs. The legislation also requires issuers with a specialty drug tier to create an exceptions process for enrollees.
- Twelve unique platinum offerings in the 2015 exchange.
- Issuers must maintain a network that is sufficient in numbers and types of health care providers to ensure that enrollees have access to health care services without unreasonable delay.
- The premium for the 2nd lowest cost silver plan is 5% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Louisiana is a

High-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Louisiana is a

Low-Performing State

LOUISIANA HIGHLIGHTS

Louisiana's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 101,800 Louisianans selected an exchange plan through HealthCare.gov. About 19% of Louisiana residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Louisiana has not expanded Medicaid.

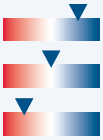
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Six carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Louisiana is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Louisiana is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Louisiana has not expanded Medicaid, which would provide coverage for an estimated 364,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Louisiana is a

Low-Performing State

A MORE PATIENT-FOCUSED LOUISIANA MARKETPLACE

Louisiana has not exercised its full authority to regulate the exchange to promote patient protections. Louisiana's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Louisiana would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Louisiana has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Louisiana could also become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for Louisiana to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 364,000 Louisianans.

METHODOLOGY

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1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Maine Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- Maine enacted legislation limiting out-of-pocket spending for prescription drugs subject to coinsurance to $3,500 per year.
- No unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 4% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Maine is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Maine is a

Low-Performing State

MAINE HIGHLIGHTS

Maine's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 44,300 Mainers selected an exchange plan through HealthCare.gov. About 36% of Maine residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Maine has not expanded Medicaid.

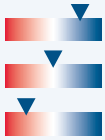
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Four carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Maine is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Maine is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Maine has not expanded Medicaid, which would provide coverage for an estimated 38,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Maine is a

Low-Performing State

A MORE PATIENT-FOCUSED MAINE MARKETPLACE

Maine has not exercised its full authority to regulate the exchange to promote patient protections. Maine's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Maine would have more control over exchange plans if the state opted to create a state-based exchange. Maine has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for Maine to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 38,000 residents.

METHODOLOGY

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Maryland Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- Maryland enacted legislation capping patient cost sharing for specialty tier drugs.
- Four unique platinum plans in the 2015 exchange.
- Maryland allows the state exchange to deny certification to health plans that do not meet the standards of network adequacy for the plan service area.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Maryland is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Maryland's exchange website has a provider search tool, access to plans' formularies, as well as filters for search results. The website lacks a formulary search tool and a calculator to help estimate tax credit or out of pocket amounts.
- Maryland requires plan formulary documents to list tiering and cost-sharing information. Also, plan filings to the Department of Insurance must indicate which drugs are covered under the medical benefit.

For transparency metrics, relative to other states, Maryland is a

High-Performing State

MARYLAND HIGHLIGHTS

Maryland established a state-based exchange, called Maryland Health Connection.

In the 2014 plan year, 81,000 Marylanders selected an exchange plan through the Maryland Health Connection. About 18% of Maryland residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Maryland expanded Medicaid effective January 1, 2014.

PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- Maryland requires health insurance companies to offer catastrophic coverage options and requires plans by a single issuer to have distinct differences.
- Its effective rate review program allows the state to manage premium increases.[3]
- Six carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Maryland is a

High-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Maryland rates exchange plans using a five-star quality score based on 2013 quality and performance data from the issuers' similar, off-exchange plans.
- No state action on standardized display of information.

For uniformity metrics, relative to other states, Maryland is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- Health plans in 2015 must allow new enrollees to receive care from their providers for certain conditions or services for a set amount of time, even if those providers are not in their new health plan's network. Plans must also notify new enrollees of these rights.[4]
- Maryland expanded Medicaid, which now covers an estimated 287,000 people in the state.

For continutity-of-care metrics, relative to other states, Maryland is a

High-Performing State

A MORE PATIENT-FOCUSED MARYLAND MARKETPLACE

Maryland has achieved considerable success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients.

However, Maryland has not exercised its full authority to regulate the exchange market to promote patient protections. Through legislative or other state action, Maryland could standardize benefit designs to better manage patients' out-of-pocket expenses. The state has few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Maryland may want to further exercise its active purchasing power to increase competition in the exchange market and attract more health plans which can help to keep premiums stable from year to year.

METHODOLOGY

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

Massachusetts Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ● Twenty-four unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 8% less in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Massachusetts is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ● Massachusetts' website allows consumers to filter plan options and has links to plans' provider directories and formularies. The website also features a provider search tool. However, the website lacks a formulary search tool and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Massachusetts is an

Average-Performing State

MASSACHUSETTS HIGHLIGHTS

Massachusetts established a state-based exchange, called the Massachusetts Health Connector.

In the 2014 plan year, 31,700 residents in Massachusetts selected an exchange plan through the Health Connector. About 8% of Massachusetts residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Massachusetts expanded Medicaid, effective in 2014.

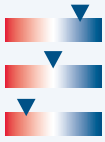
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- Massachusetts limits the number of bids an issuer may submit and requires issuers to offer plans in all four metal levels.
- Its effective rate review program allows the state to manage premium increases.[3]
- Twelve carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Massachusetts is a

High-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- Massachusetts standardized benefit designs.
- In 2014, the Massachusetts Health Connector developed quality ratings on a four-star scale based on the National Committee for Quality Assurance's plan report card, reflecting issuer evaluations from July 2013. However, in 2015 the ratings are no longer displayed. The Health Connector has not publicly made a rationale for the removal of ratings.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Massachusetts is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- Massachusetts provides supplemental premium subsidies for individuals with incomes below 300% of the federal poverty level.
- Massachusetts expanded Medicaid, which now covers an estimated 276,000 people in the state.

For continuity-of-care metrics, relative to other states, Massachusetts is a

High-Performing State

A MORE PATIENT-FOCUSED MASSACHUSETTS MARKETPLACE

Massachusetts has achieved considerable success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients.

However, Massachusetts has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Massachusetts could enhance contracting requirements for plan information transparency and standardize the display of plan information. The state also could consider oversight activities that would screen exchange plans for discrimination, and enhance network adequacy requirements. Further, patients would benefit if the state displayed quality rating measures, as these measures would better inform plan selection.

METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

Michigan Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Ten unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 5% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Michigan is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Michigan is a

Low-Performing State

MICHIGAN HIGHLIGHTS

Michigan's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 272,500 Michiganians selected an exchange plan through HealthCare.gov. About 40% of Michigan residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Michigan expanded Medicaid, effective April 1, 2014.

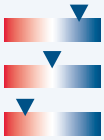
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- Michigan ties issuer participation inside and outside of the exchange.
- Its effective rate review program allows the state to manage premium increases.[3]
- Fifteen carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Michigan is a

High-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Michigan is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Michigan expanded Medicaid, which now covers an estimated 239,000 people.

For continuity-of-care metrics, relative to other states, Michigan is an

Average-Performing State

A MORE PATIENT-FOCUSED MICHIGAN MARKETPLACE

Michigan has not exercised its full authority to regulate the exchange to promote patient protections. Michigan's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Mighigan would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Michigan has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Michigan also could become an active purchaser to have more authority over plan participation. As Michigan implements the Medicaid waiver program, the state should ensure the waiver program preserves patient protections inherent in traditional Medicaid.

METHODOLOGY

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

Minnesota Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Four unique platinum plans in the 2015 exchange.
- Minnesota enacted legislation that set maximum travel distance and time from a patient to covered provider, to ensure reasonable access to care.
- The premium for the 2nd lowest cost silver plan is 19% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Minnesota is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Minnesota's website allows consumers to filter plan options. However the website lacks links to plans' provider directories and formularies, as well as formulary and provider search tools. The website also lacks calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Minnesota is a

Low-Performing State

MINNESOTA HIGHLIGHTS

Minnesota established a state-based exchange, called MNSure.

In the 2014 plan year, 60,100 Minnesotans selected an exchange plan through MNSure. About 22% of Minnesota residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Minnesota expanded Medicaid, effective January 1, 2014.

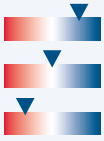
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- Minnesota ties issuer participation inside and outside of the exchange, and requires plans by a single issuer to have distinct differences.
- Its effective rate review program allows the state to manage premium increases.[3]
- Five carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Minnesota is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Minnesota formed an Exchange Measurement and Reporting Task Work group that examined proposed quality measures; however, no quality measures have been finalized.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Minnesota is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Minnesota expanded Medicaid, which now covers an estimated 301,000 people in the state.

For continutity-of-care metrics, relative to other states, Minnesota is an

Average-Performing State

A MORE PATIENT-FOCUSED MINNESOTA MARKETPLACE

Minnesota has some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Minnesota has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Minnesota could standardize benefit designs and plan benefit materials. Minnesota should also work to develop tools for patients to use on the website that increase transparency to better inform plan selection. Examples of tools to help transparency include: formulary and provider search tools, out-of-pocket calculators, as well as a quality rating system. The state also could consider oversight activities that better monitor exchange plans for discriminationary benefit designs. As a state-based exchange, Minnesota could exert even more influence over the exchange by becoming an active purchaser, which could help the state better manage increasing premiums.

METHODOLOGY

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

Mississippi Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Three unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 26% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Mississippi is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Mississippi is a

Low-Performing State

MISSISSIPPI HIGHLIGHTS

Mississippi's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 61,500 Mississippians selected an exchange plan through HealthCare.gov. About 22% of Mississippi residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Mississippi has not expanded Medicaid.

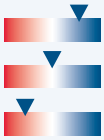
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Three carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Mississippi is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Mississippi is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Mississippi has not expanded Medicaid, which would provide coverage for an estimated 203,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Mississippi is a

Low-Performing State

A MORE PATIENT-FOCUSED MISSISSIPPI MARKETPLACE

Mississippi has not exercised its full authority to regulate the exchange to promote patient protections. Mississippi's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Mississippi would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Mississippi has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Mississippi also could become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for Mississippi to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 203,000 Mississippians.

METHODOLOGY

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Missouri Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Three unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 5% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Missouri is a

Low-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Missouri is a

Low-Performing State

MISSOURI HIGHLIGHTS

Missouri's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 152,300 Missourians selected an exchange plan through HealthCare.gov. About 24% of Missouri residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Missouri has not expanded Medicaid.

PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Missouri does not have an effective rate review program.[3]
- Seven carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Missouri is a

Low-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Missouri is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Missouri has not expanded Medicaid, which would provide coverage for an estimated 283,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Missouri is a

Low-Performing State

A MORE PATIENT-FOCUSED MISSOURI MARKETPLACE

Missouri has not exercised its full authority to regulate the exchange to promote patient protections. Missouri's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Missouri would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Missouri has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Missouri also could become an active purchaser, which could help the state better manage increasing premiums. Another critical step towards a patient-friendly health insurance market would be for Missouri to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 283,000 Missourians.

METHODOLOGY

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Montana Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ● Montana requires that health insurance companies cover all prescription drugs equally at a flat dollar copay for all plans with an actuarial value equal to, or greater than 70%.
- ◐ Two unique platinum offerings in the 2015 exchange.
- ● Montana has implemented increased network adequacy standards for health plans. Plans are required to include at least 80% of all Essential Community Providers—a standard that exceeds the federal requirement of 30%.
- ● The premium for the 2nd lowest cost silver plan is 7% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Montana is a

High-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Montana is a

Low-Performing State

MONTANA HIGHLIGHTS

Montana's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 36,600 Montanans selected an exchange plan through HealthCare.gov. About 30% of Montana residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Montana has not expanded Medicaid.

PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Five carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Montana is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Montana is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Montana has not expanded Medicaid, which would provide coverage for an estimated 63,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Montana is a

Low-Performing State

A MORE PATIENT-FOCUSED MONTANA MARKETPLACE

While Montana has taken steps to limit discrimination, it has not exercised its full authority to regulate the exchange to promote patient protections. Montana's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Montana would have more control over exchange plans if the state opted to create a state-based exchange. Montana has yet to establish standards that would increase transparency or uniformity, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Montana also could become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for Montana to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 63,000 Montanans.

METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Nebraska Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum plan offering in the 2015 exchange.
- Nebraska enacted legislation requiring managed care issuers to maintain a network that is sufficient in numbers and types of providers to ensure that enrollees have access to healthcare services without unreasonable delay.
- The premium for the 2nd lowest cost silver plan is 3% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Nebraska is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Nebraska is a

Low-Performing State

NEBRASKA HIGHLIGHTS

Nebraska's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 43,000 Nebraskans selected an exchange plan through HealthCare.gov. About 18% of Nebraska residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Nebraska has not expanded Medicaid.

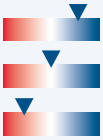
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Four carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Nebraska is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Nebraska is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Nebraska has not expanded Medicaid, which would provide coverage for an estimated 56,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Nebraska is a

Low-Performing State

A MORE PATIENT-FOCUSED NEBRASKA MARKETPLACE

Nebraska has not exercised its full authority to regulate the exchange to promote patient protections. Nebraska's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Nebraska would have more control over exchange plans if the state opted to create a state-based exchange. Nebraska has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for Nebraska to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 56,000 Nebraskans.

METHODOLOGY

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Nevada Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Nine unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is less than 1% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Nevada is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Nevada is a

Low-Performing State

NEVADA HIGHLIGHTS

Nevada is a supported state-based exchange. Although the state created its own exchange, called Nevada Health Link, it is enrolling individuals through the federal enrollment portal, HealthCare.gov.

In the 2014 plan year, 43,000 Nevadans selected an exchange plan through Nevada Health Link. About 17% of Nevada residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Nevada expanded Medicaid, effective in 2014.

PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing
Average-Performing
Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Seven carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Nevada is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Nevada is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Nevada expanded Medicaid, which now covers an estimated 216,000 people in the state.

For continuity-of-care metrics, relative to other states, Nevada is an

Average-Performing State

A MORE PATIENT-FOCUSED NEVADA MARKETPLACE

Nevada has not exercised its full authority to regulate the exchange to promote patient protections. Although Nevada is a state-based exchange, its reliance on HealthCare.gov for enrollment reduces its ability to influence shopping tools available to customers. Nevada would have more control over exchange plans if the state operated its own enrollment platform. Additionally, through legislative or other state action, Nevada could standardize benefit designs or plan benefit materials. The state also could consider oversight activities that would screen exchange plans for discrimination, and promote continuity-of-care requirements to ensure that patients with chronic conditions have access to care.

METHODOLOGY

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

New Hampshire Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum offering in the 2015 exchange.
- New Hampshire enacted legislation requiring issuers to maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure adequate access to healthcare services without unreasonable delay.
- The premium for the 2nd lowest cost silver plan is 15% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, New Hampshire is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, New Hampshire is a

Low-Performing State

NEW HAMPSHIRE HIGHLIGHTS

New Hampshire established a state-federal partnership exchange. The state is responsible for managing plan participation and customer assistance in the exchange. New Hampshire residents use the federal exchange, HealthCare.gov, to compare and purchase coverage.

In the 2014 plan year, 40,300 New Hampshirites selected an exchange plan through HealthCare.gov. About 39% of New Hampshire residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

New Hampshire expanded Medicaid, effective in 2014.

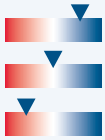
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Six carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, New Hampshire is an

Average-Performing State

UNIFORMITY

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, New Hampshire is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- New Hampshire expanded Medicaid under a premium assistance model, which now covers an estimated 40,000 people.

For continuity-of-care metrics, relative to other states, New Hampshire is an

Average-Performing State

A MORE PATIENT-FOCUSED NEW HAMPSHIRE MARKETPLACE

New Hampshire's partial reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. New Hampshire would have more control over exchange plans if the state opted to create a state-based exchange. New Hampshire has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

As New Hampshire implements the premium assistance model, the state should ensure the model preserves patient protections inherent in Medicaid.

METHODOLOGY

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New Jersey Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Six unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 2% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, New Jersey is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, New Jersey is a

Low-Performing State

NEW JERSEY HIGHLIGHTS

New Jersey's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 161,800 New Jerseyans selected an exchange plan through HealthCare.gov. About 27% of New Jersey residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

New Jersey expanded Medicaid, effective January 1, 2014.

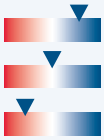
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Five carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, New Jersey is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, New Jersey is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- New Jersey expanded Medicaid, which now covers an estimated 374,000 people in the state.

For continuity-of-care metrics, relative to other states, New Jersey is an

Average-Performing State

A MORE PATIENT-FOCUSED NEW JERSEY MARKETPLACE

New Jersey has not exercised its full authority to regulate the exchange to promote patient protections. New Jersey's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. New Jersey would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. New Jersey has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, New Jersey also could become an active purchaser.

METHODOLOGY

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New Mexico Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum offering in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 12% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, New Mexico is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, New Mexico is a

Low-Performing State

NEW MEXICO HIGHLIGHTS

New Mexico is a supported state-based exchange. Although the state created its own exchange, called beWellnm, it is enrolling individuals through the federal enrollment portal, HealthCare.gov.

In the 2014 plan year, 32,100 New Mexicans selected an exchange plan through HealthCare.gov. About 21% of New Mexico residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

New Mexico expanded Medicaid, effective in 2014.

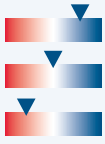
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- New Mexico limited 2015 exchange participation to only those issuers that joined in 2014. New issuers may offer coverage through the exchange starting in 2016.
- Its effective rate review program allows the state to manage premium increases.[3]
- Seven carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, New Mexico is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, New Mexico is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- New Mexico expanded Medicaid, which now covers an estimated 184,000 people in the state.

For continuity-of-care metrics, relative to other states, New Mexico is an

Average-Performing State

A MORE PATIENT-FOCUSED NEW MEXICO MARKETPLACE

New Mexico has not exercised its full authority to regulate the exchange to promote patient protections. Although New Mexico is a state-based exchange, its reliance on HealthCare.gov for enrollment reduces its ability to influence shopping tools available to customers. New Mexico would have more control over exchange plans if the state operated its own enrollment platform; however, its recent decision to halt development of its own exchange enrollment website limits opportunities to increase health plan transparency and improve uniformity of content. As a state-based exchange, New Mexico could become an active purchaser, take further action to protect patients from discrimination, and develop continuity-of-care requirements to help patients maintain access to care. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

METHODOLOGY

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1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

New York Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- New York was the first state to enact legislation to limit specialty tiers. The law prohibits plans from charging cost-sharing amounts that exceed amounts for non-preferred brand or the equivalent.
- Thirty-nine unique platinum offerings in the 2015 exchange.
- New York required plans to allow in-network cost sharing for out-of-network providers when an appropriate provider is not available within the plan's network. Additionally, network directories must be updated within 15 days of providers joining or leaving a plan's network.
- The premium for the 2nd lowest cost silver plan is 2% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, New York is a

High-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- New York's website links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks formulary and provider search tools and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, New York is a

Low-Performing State

NEW YORK HIGHLIGHTS

New York established a state-based exchange, called New York State of Health.

In the 2014 plan year, 370,600 New Yorkers selected an exchange plan through New York State of Health. About 30% of New York residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

New York expanded Medicaid, effective January 1, 2014.

PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- New York requires multi-year contracts, limits the number of bids submitted by issuers, ties participation outside and inside the exchange, and requires plans to offer products in specific metals levels, including catastrophic plans.
- Its effective rate review program allows the state to manage premium increases.[3]
- Seventeen carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, New York is a

High-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- New York standardized benefit designs.
- New York rates exhange plans using a four-star quality rating system. By 2016, New York intends to develop a five-star quality star rating system, which contains the following five domains for each product: consumer satisfaction, children's health, pregnancy care, adult health, and health conditions.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, New York is a

High-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- New York requires issuers new to the exchange in 2015 to also participate in Medicaid managed care. New York also provided additional premium subsidies beyond the federal requirement for individuals between 138 and 150 percent of the federal poverty level.
- New York expanded Medicaid, which now covers an estimated 518,000 people in the state.

For continuity-of-care metrics, relative to other states, New York is a

High-Performing State

A MORE PATIENT-FOCUSED NEW YORK MARKETPLACE

New York has achieved considerable success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients.

However, New York has not exercised its full authority to regulate the exchange to promote patient protections. Notably, the state could enact contracting requirements to enhance plan information transparency, and standardize display of plan information. Patients would also benefit from the development of an out-of-pocket calculator to estimate health expenses and better inform plan selection.

METHODOLOGY

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3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

North Carolina Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Four unique platinum offerings in the 2015 exchange.
- ◐ No state actions on network requirements.
- ● The premium for the 2nd lowest cost silver plan is 7% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, North Carolina is a

Low-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, North Carolina is a

Low-Performing State

NORTH CAROLINA HIGHLIGHTS

North Carolina's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 357,600 North Carolinians selected an exchange plan through HealthCare.gov. About 33% of North Carolina residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

North Carolina has not expanded Medicaid.

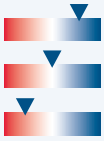
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Four carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, North Carolina is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, North Carolina is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- North Carolina has not expanded Medicaid, which would provide coverage for an estimated 511,000.[5]

For continuity-of-care metrics, relative to other states, North Carolina is a

Low-Performing State

A MORE PATIENT-FOCUSED NORTH CAROLINA MARKETPLACE

North Carolina has not exercised its full authority to regulate the exchange to promote patient protections. North Carolina's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. North Carolina would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. North Carolina has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, North Carolina also could become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for North Carolina to expand Medicaid. Expansion of Medicaid would provide health insurance for over 500,000 North Carolinians.

METHODOLOGY

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

North Dakota Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- North Dakota has no platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is less than 1% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, North Dakota is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, North Dakota is a

Low-Performing State

NORTH DAKOTA HIGHLIGHTS

North Dakota's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 10,600 North Dakotans selected an exchange plan through HealthCare.gov. About 13% of North Dakota residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

North Dakota expanded Medicaid, effective January 1, 2014.

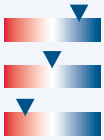
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Three carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, North Dakota is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, North Dakota is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- North Dakota expanded Medicaid, which now covers an estimated 12,000 people in the state.

For continutity-of-care metrics, relative to other states, North Dakota is an

Average-Performing State

A MORE PATIENT-FOCUSED NORTH DAKOTA MARKETPLACE

North Dakota has not exercised its full authority to regulate the exchange to promote patient protections. North Dakota's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. North Dakota would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. North Dakota has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. In addition, North Dakota's exchange does not foster competition as there are only three carriers offering coverage. As a result, there are no platinum plans offered in the state, limiting options for people who would benefit most—those with chronic conditions and disabilities. Under a different operational model, North Dakota also could become an active purchaser.

METHODOLOGY

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Ohio Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Four unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 1% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Ohio is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Ohio is a

Low-Performing State

OHIO HIGHLIGHTS

Ohio's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 154,700 Ohioans selected an exchange plan through HealthCare.gov. About 17% of Ohio residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Ohio expanded Medicaid, effective January 1, 2014.

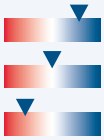
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Sixteen carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Ohio is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Ohio is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Ohio expanded Medicaid, which now covers an estimated 526,000 people in the state.

For continuity-of-care metrics, relative to other states, Ohio is an

Average-Performing State

A MORE PATIENT-FOCUSED OHIO MARKETPLACE

Ohio has not exercised its full authority to regulate the exchange to promote patient protections. Ohio's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Ohio would have more control over exchange plans if the state opted to create a state-based exchange. Ohio has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Ohio also could become an active purchaser. The state has few platinum plans, which limits options for the people who would benefit the most—those with chronic conditions and disabilities.

METHODOLOGY

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Oklahoma Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ● One unique platinum offering in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 9% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Oklahoma is a


Low-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Oklahoma is a


Low-Performing State

OKLAHOMA HIGHLIGHTS

Oklahoma's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 69,200 Oklahomans selected an exchange plan through HealthCare.gov. About 17% of Oklahoma residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Oklahoma has not expanded Medicaid.

PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.


High-Performing


Average-Performing


Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Oklahoma does not have an effective rate review.[3]
- Five carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Oklahoma is a

Low-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Oklahoma is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Oklahoma has not expanded Medicaid, which would provide coverage for an estimated 201,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Oklahoma is a

Low-Performing State

A MORE PATIENT-FOCUSED OKLAHOMA MARKETPLACE

Oklahoma has not exercised its full authority to regulate the exchange to promote patient protections. Oklahoma's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Oklahoma would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Oklahoma has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Oklahoma also could become an active purchaser, which could help the state better manage increasing premiums. In addition, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Another critical step towards a patient-friendly health insurance market would be for Oklahoma to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 201,000 Oklahomans.

METHODOLOGY

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Oregon Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Two unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 6% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Oregon is a

Low-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Oregon is a

Low-Performing State

OREGON HIGHLIGHTS

Oregon is a supported state-based exchange. Although the state created its own exchange, called Cover Oregon, it is enrolling individuals through the federal enrollment portal, HealthCare.gov.

In the 2014 plan year, 77,300 Oregonians selected an exchange plan through HealthCare.gov. About 24% of Oregon residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Oregon expanded Medicaid, effective in 2014.

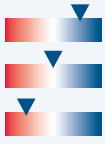
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- Oregon requires multi-year contracts and limits the number of bids submitted by issuers.
- Its effective rate review program allows the state to manage premium increases.[3]
- Eleven carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Oregon is a

High-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- Oregon standardized benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Oregon is a

High-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Oregon expanded Medicaid, which now covers an estimated 405,000 people in the state.

For continuity-of-care metrics, relative to other states, Oregon is an

Average-Performing State

A MORE PATIENT-FOCUSED OREGON MARKETPLACE

Oregon has not exercised its full authority to regulate the exchange to promote patient protections. Although Oregon is a state-based exchange, its reliance on HealthCare.gov for enrollment reduces its ability to influence shopping tools available to customers. Oregon would have more control over exchange plans if the state operated its own enrollment platform. The state also could consider oversight activities that would screen exchange plans for discrimination, and bolster requirements for plan information transparency. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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Pennsylvania Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ● Twenty unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 11% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Pennsylvania is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Pennsylvania is a

Low-Performing State

PENNSYLVANIA HIGHLIGHTS

Pennsylvania's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 318,100 Pennsylvanians selected an exchange plan through HealthCare.gov. About 35% of Pennsylvania residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Pennsylvania expanded Medicaid, effective January 1, 2015.

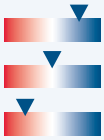
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Eleven carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Pennsylvania is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Pennsylvania is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Pennsylvania expanded Medicaid, which now covers an estimated 2,000 people.

For continuity-of-care metrics, relative to other states, Pennsylvania is an

Average-Performing State

A MORE PATIENT-FOCUSED PENNSYLVANIA MARKETPLACE

Pennsylvania has not exercised its full authority to regulate the exchange to promote patient protections. Pennsylvania's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Pennsylvania would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Pennsylvania has yet to establish exchange standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Pennsylvania also could become an active purchaser.

METHODOLOGY

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Rhode Island Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- No unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 11% lower in 2015, than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Rhode Island is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Rhode Island's website allows consumers to filter plan options and has links to plans' provider directories and formularies. The website also features a provider search tool, and a calculator to help estimate tax credit amounts. However, the website lacks a formulary search tool.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Rhode Island is an

Average-Performing State

RHODE ISLAND HIGHLIGHTS

Rhode Island established a state-based exchange, called HealthSource RI.

In the 2014 plan year, 28,500 Rhode Islanders selected an exchange plan through HealthSource RI. About 39% of Rhode Island residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Rhode Island expanded Medicaid, effective in 2014.

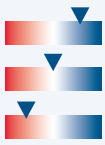
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange.
- Its effective rate review program allows the state to manage premium increases.[3]
- Three carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Rhode Island is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Rhode Island is developing quality rating measures for use in future plan years.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Rhode Island is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.
- Rhode Island expanded Medicaid, which now covers an estimated 73,000 people.[4]

For continuity-of-care metrics, relative to other states, Rhode Island is an

Average-Performing State

A MORE PATIENT-FOCUSED RHODE ISLAND MARKETPLACE

Rhode Island has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Rhode Island has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Rhode Island could standardize benefit designs or plan benefit materials. The state also could consider oversight activities to screen exchange plans for discrimination, and enhance network adequacy requirements. Patients would benefit from the development of quality rating measures to better inform plan selection. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

METHODOLOGY

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South Carolina Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum offering in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, South Carolina is a

Low-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, South Carolina is a

Low-Performing State

SOUTH CAROLINA HIGHLIGHTS

South Carolina's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 118,300 South Carolinians selected an exchange plan through HealthCare.gov. About 27% of South Carolina residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

South Carolina has not expanded Medicaid.

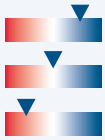
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Seven carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, South Carolina is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, South Carolina is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- South Carolina has not expanded Medicaid, which would provide coverage for an estimated 289,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, South Carolina is a

Low-Performing State

A MORE PATIENT-FOCUSED SOUTH CAROLINA MARKETPLACE

South Carolina has not exercised its full authority to regulate the exchange to promote patient protections. South Carolina's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. South Carolina would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. South Carolina has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, South Carolina also could become an active purchaser, which could help the state better manage increasing premiums. Further, the state has only a single platinum plan, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for South Carolina to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 289,000 South Carolina residents.

METHODOLOGY

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South Dakota Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum offering in the 2015 exchange.
- South Dakota requires issuers to include any willing and qualified provider in plan networks.
- The premium for the 2nd lowest cost silver plan is 3% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, South Dakota is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, South Dakota is a

Low-Performing State

SOUTH DAKOTA HIGHLIGHTS

South Dakota's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 13,100 South Dakotans selected an exchange plan through HealthCare.gov. About 13% of South Dakota residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

South Dakota has not expanded Medicaid.

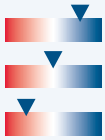
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Three carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, South Dakota is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, South Dakota is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- South Dakota has not expanded Medicaid, which would provide coverage for an estimated 40,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, South Dakota is a

Low-Performing State

A MORE PATIENT-FOCUSED SOUTH DAKOTA MARKETPLACE

South Dakota has not exercised its full authority to regulate the exchange to promote patient protections. South Dakota's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. South Dakota would have more control over exchange plans if the state opted to create a state-based exchange. South Dakota has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for South Dakota to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 40,000 South Dakotans.

METHODOLOGY

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Tennessee Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Ten unique platinum offerings in the 2015 exchange.
- Tennessee enacted legislation requiring each managed care issuer to maintain a network that is sufficient in numbers and types of providers in order to ensure access without unreasonable delay.
- The premium for the 2nd lowest cost silver plan is 8% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Tennessee is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Tennessee is a

Low-Performing State

TENNESSEE HIGHLIGHTS

Tennessee's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 151,400 Tennesseeans selected an exchange plan through HealthCare.gov. About 26% of Tennessee residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Tennessee has not expanded Medicaid.

PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Seven carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Tennessee is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Tennessee is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Tennessee has not expanded Medicaid, which would provide coverage for an estimated 266,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Tennessee is a

Low-Performing State

A MORE PATIENT-FOCUSED TENNESSEE MARKETPLACE

Tennessee has not exercised its full authority to regulate the exchange to promote patient protections. Tennessee's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Tennessee would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Tennessee has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Tennessee also could become an active purchaser, which could help the state better manage increasing premiums. Another critical step towards a patient-friendly health insurance market would be for Tennessee to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 266,000 Tennesseeans.

METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

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5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Texas Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Eleven unique platinum offerings in the 2015 exchange.
- Texas enacted legislation requiring the insurance commissioner to adopt network adequacy standards that ensure access to "a full range" of physician providers.
- The premium for the 2nd lowest cost silver plan is 5% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Texas is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Texas is a

Low-Performing State

TEXAS HIGHLIGHTS

Texas' exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 733,800 Texans selected an exchange plan through HealthCare.gov. About 24% of Texas residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Texas has not expanded Medicaid.

PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Texas does not have an effective rate review program.[3]
- Fourteen carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Texas is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Texas is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Texas has not expanded Medicaid, which would provide coverage for an estimated 1,727,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Texas is a

Low-Performing State

A MORE PATIENT-FOCUSED TEXAS MARKETPLACE

Texas has not exercised its full authority to regulate the exchange to promote patient protections. Texas' reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Texas would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Texas has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Texas also could become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for Texas to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 1.7 million Texans.

METHODOLOGY

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

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Utah Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum offering in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Utah is a

Low-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Utah is a

Low-Performing State

UTAH HIGHLIGHTS

Utah's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 84,600 Utahans selected an exchange plan through HealthCare.gov. About 23% of Utah residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Utah has not expanded Medicaid.

PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Seven carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Utah is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Utah is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Utah has not expanded Medicaid, which would provide coverage for an estimated 93,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Utah is a

Low-Performing State

A MORE PATIENT-FOCUSED UTAH MARKETPLACE

Utah has not exercised its full authority to regulate the exchange to promote patient protections. Utah's reliance on the federal government to run the exchange reduces the state's influence over its own individual health insurance market. Utah would have more control over exchange plans if the state opted to create a state-based exchange. Utah has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Utah also could become an active purchaser, which could help the state better manage increasing premiums. Further, the state has only a single platinum plan, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for Utah to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 93,000 Utahans.

METHODOLOGY

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Vermont Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Two unique platinum offerings in the 2015 exchange.
- ● Vermont enacted legislation requiring exchange plans to meet specified minimum network adequacy standards.
- ● The premium for the 2nd lowest cost silver plan is 6% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Vermont is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ● Vermont's website has links to plans' provider directories and formularies as well as a calculator to estimate projected subsidy amounts. However, because of required sensitive information to browse plans, NHC was unable to fully examine the exchange enrollment portal; therefore, it is unclear if the website has formulary and provider search tools or allows consumers to filter plan options.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Vermont is an

Average-Performing State

VERMONT HIGHLIGHTS

Vermont established a state-based exchange, called Vermont Health Connect.

In the 2014 plan year, 31,500 Vermont residents selected an exchange plan through Vermont Health Connect. About 70% of Vermont residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Vermont expanded Medicaid, effective January 1, 2014.

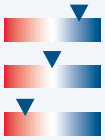
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing – the state actively negotiates with plans to participate in the exchange.
- Vermont ties participation outside and inside the exchange and requires plans by a single issuer to have distinct differences.
- Its effective rate review program allows the state to manage premium increases.[3]
- Two carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Vermont is a

High-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- Vermont standardized benefit designs.
- Vermont does not have a quality rating system in place for the 2015 plan year, and has not released materials to date on the development of a quality rating system for the 2016 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Vermont is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- Vermont reduces premiums and cost sharing, beyond federally funded subsidies, for qualifying exchange enrollees.
- Vermont expanded Medicaid, which now covers an estimated 87,000 people in the state.

For continutity-of-care metrics, relative to other states, Vermont is a

High-Performing State

A MORE PATIENT-FOCUSED VERMONT MARKETPLACE

Vermont has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Vermont has not exercised its full authority to regulate the exchange to promote patient protections. The state could improve its transparency by allowing the general public to view exchange plan offerings without creating an account. For those able to view exchange offerings, Vermont may pass legislation requiring greater clarity on plan benefits and develop quality rating measures to better inform patients' plan selection. In addition, Vermont's exchange does not foster competition as there are only two carriers offering coverage. As a result of the lack of competition, there are few platinum plans offered in the state, limiting options for the people who would benefit most—those with chronic conditions and disabilities.

METHODOLOGY

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Virginia Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Two unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Virginia is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Virginia is a

Low-Performing State

VIRGINIA HIGHLIGHTS

Virginia's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 216,400 Virginians selected an exchange plan through HealthCare.gov. About 26% of Virginia residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Virginia has not expanded Medicaid.

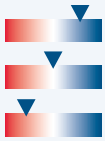
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Nine carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Virginia is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Virginia is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- Virginia enacted legislation requiring issuers to notify enrollees at least 30 days before certain mid-year changes to formularies that would result in higher out-of-pocket costs.
- Virginia has not expanded Medicaid, which would provide coverage for an estimated 314,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Virginia is an

Average-Performing State

A MORE PATIENT-FOCUSED VIRGINIA MARKETPLACE

Virginia has not exercised its full authority to regulate the exchange to promote patient protections. Virginia's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Virginia would have more control over exchange plans if the state opted to create a state-based exchange. Virginia has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Virginia also could become an active purchaser, which could help the state better manage increasing premiums. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for Virginia to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 314,000 Virginians.

METHODOLOGY

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Washington Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- Washington has issued regulations that limit discrimination in exchange plans by setting increased standards for coverage and grants the insurance commissioner broad authority to reject plans with discriminatory benefits.
- Five unique platinum plans in the 2015 exchange.
- Washington requires minimum standards for provider networks, such as having access to urgent care within a set timeframe. The state also requires that in-network costs apply to out-of-network providers in certain conditions.[2]
- The premium for the 2nd lowest cost silver plan is 10% lower in 2015 than it was in 2014.[3]

For non-discrimination metrics, relative to other states, Washington is a

High-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Washington's exchange website has a provider search tool and the ability to filter search results. The website lacks a formulary search tool, access to plans' formularies and provider networks, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Washington is an

Average-Performing State

WASHINGTON HIGHLIGHTS

Washington established a state-based exchange, called Washington Healthplanfinder.

In the 2014 plan year, 147,900 Washingtonians selected an exchange plan through Washington Healthplanfinder. About 29% of Washington residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Washington expanded Medicaid, effective January 1, 2014.

PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing
Average-Performing
Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- Washington requires exchange plans to offer catastrophic coverage options.
- Its effective rate review program allows the state to manage premium increases.[4]
- Ten carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Washington is a

High-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Washington has plans to develop a quality rating system. Currently, the exchange displays health plans' quality improvement strategies to improve health outcomes, increase patient safety, and prevent hospital readmissions.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Washington is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[5]
- Washington expanded Medicaid, which now covers an estimated 445,000 people in the state.

For continutity-of-care metrics, relative to other states, Washington is an

Average-Performing State

A MORE PATIENT-FOCUSED WASHINGTON MARKETPLACE

Washington has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Washington has not exercised its full authority to regulate the exchange market to promote patient protections. Through legislative or other state action, Washington could standardize benefit designs or plan benefit materials. The state has few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan. Since it is a state-based exchange, Washington could exert even more influence over the exchange by becoming an active purchaser. Finally, Washington could act to make the website more patient-focused with tools to make plan information standardized and more accessible.

METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 National Conference of State Legislatures, "Insurance Carriers and Access to Healthcare Providers: Network Adequacy," November 30, 2014, accessed via: http://www.ncsl.org/research/health/insurance-carriers-and-access-to-healthcare-providers-network-adequacy.aspx

3 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

4 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

5 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

West Virginia Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- West Virginia has no platinum offerings in the 2015 exchange.
- No state action on provider network requirements
- The premium for the 2nd lowest cost silver plan is 8% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, West Virginia is a

Low-Performing State

TRANSPARENCY

TO PROMOTE BETTER CONSUMER ACCESS TO INFORMATION ABOUT COVERED SERVICES AND COSTS IN EXCHANGE PLANS.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, West Virginia is a

Low-Performing State

WEST VIRGINIA HIGHLIGHTS

West Virginia established a state-federal partnership exchange. The state is responsible for managing plan participation in the exchange. West Virginia residents use the federal exchange, HealthCare.gov, to compare and purchase coverage.

In the 2014 plan year, 19,900 West Virginians selected an exchange plan through HealthCare.gov. About 18% of West Virginia residents who are eligible for subsidized exchange coverage enrolled in an exchange plan in 2014.[1]

West Virginia expanded Medicaid effective January 1, 2014.

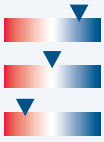
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Two carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, West Virginia is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, West Virginia is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- West Virginia expanded Medicaid, which now covers an estimated 174,000 people in the state.

For continuity-of-care metrics, relative to other states, West Virginia is an

Average-Performing State

A MORE PATIENT-FOCUSED WEST VIRGINIA MARKETPLACE

West Virginia has not exercised its full authority to regulate the exchange to promote patient protections. West Virginia's partial reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. West Virginia would have more control over exchange plans if the state opted to create a fully state-based exchange. West Virginia has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, West Virginia also could become an active purchaser. In addition, West Virginia's exchange does not foster competition as there are only two carriers offering coverage. As a result of the lack of competition and contracting requirements, there are no platinum plans offered in the state, limiting options for the people who would benefit most—those with chronic conditions and disabilities.

METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

Wisconsin Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Thirty-five unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 6% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Wisconsin is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Wisconsin is a

Low-Performing State

WISCONSIN HIGHLIGHTS

Wisconsin's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 139,800 Wisconsinites selected an exchange plan through HealthCare.gov. About 29% of Wisconsin's residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Wisconsin has not expanded Medicaid.

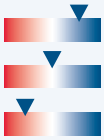
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Sixteen carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Wisconsin is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Wisconsin is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Wisconsin has not expanded Medicaid, which would provide coverage for an estimated 53,000 people in the state.[5] Rather, Wisconsin has actually reduced the number of people in Medicaid by shifting some beneficiaries into exchanges with financial assistance to help pay monthly premiums.

For uniformity metrics, relative to other states, Wisconsin is a

Low-Performing State

A MORE PATIENT-FOCUSED WISCONSIN MARKETPLACE

Wisconsin's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Wisconsin would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management exchange model. Wisconsin has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Wisconsin also could become an active purchaser, which could help the state better manage increasing premiums. Another critical step towards a patient-friendly health insurance market would be for Wisconsin to expand Medicaid, rather than shift people out of the program into the exchanges; this current practice imposes more of a cost-burden and in some instances more limited coverage. Expansion of Medicaid would provide health insurance for nearly 53,000 million Wisconsinites.

METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

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5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

Wyoming Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Two unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Wyoming is an

Average-Performing State

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Wyoming is a

Low-Performing State

WYOMING HIGHLIGHTS

Wyoming's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 12,000 Wyomingites selected an exchange plan through HealthCare.gov. About 18% of Wyoming residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Wyoming has not expanded Medicaid.

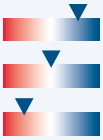
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Wyoming does not have an effective rate review program.[3]
- Two carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Wyoming is a

Low-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Wyoming is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Wyoming has not expanded Medicaid, which would provide coverage for an estimated 27,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Wyoming is a

Low-Performing State

A MORE PATIENT-FOCUSED WYOMING MARKETPLACE

Wyoming has not exercised its full authority to regulate the exchange to promote patient protections. Wyoming's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Wyoming would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Wyoming has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Wyoming also could become an active purchaser, which could help the state better manage increasing premiums. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for Wyoming to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 27,000 Wyomingites.

METHODOLOGY

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