

REPORT

FINAL REPORT

Transitions and Continuity of Care: A Discussion of Marketplace, Medicaid, and CHIP Issuers' Decisions and Strategies

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EXECUTIVE SUMMARY

Background and objectives

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) ushered in a new era of health insurance coverage, including the establishment of a wider range of health insurance products than previously was available or accessible to uninsured or underinsured Americans. Many of these new products are available for people at all income levels, but they are especially critical for lower-income individuals and families who are more likely to lack coverage and can benefit most from the subsidies included in the Act. Millions of lower income individuals and families will transition across programs (Marketplace, Medicaid, and the Children's Health Insurance Program [CHIP]) as their income changes.

This report is the second in a two-part study aimed at learning more about how easily individuals can maintain their primary care physicians as they transition across programs. The first part of the study looked at the overlap in health insurance issuers and associated primary care physician networks across the Marketplace, Medicaid, and CHIP to understand the continuity-of-care implications for enrollees who may transition between programs. In this second report, we explore in more depth the reasons behind issuer decisions on program participation and provider network design, how they respond to and perceive the federal and state regulatory framework in which they operate, and major lessons learned during the first open enrollment period.

Methods

Both this and the previous study focused on issuers operating in six diverse market areas. The areas selected (in order of population size) were Chicago, Illinois; Phoenix, Arizona; Louisville, Kentucky; Baltimore, Maryland; Buffalo, New York; and East Los Angeles, California. The earlier study identified 48 eligible issuers participating in the Marketplace, Medicaid, or CHIP in these market areas. In this second part of the study, we conducted interviews with a subset of those issuers, divided among five categories: those offering Marketplace coverage only (both existing commercial issuers and newly formed consumer-oriented and operated plans [CO-OPs]), Medicaid and CHIP coverage only, or both types of coverage (separated into those offering high-integration networks and those offering low-integration networks). A total of 18 issuers agreed to be interviewed; their interviews form the basis of this report. Because of the relatively small number of issuers interviewed and potential biases in response (such as the small number of issuers with high-integration networks participating), the study is not meant to answer all questions related to the topic of continuity of care, but rather to provide insights into issuers' decision-making processes. We conducted the interviews from May through July 2014 by telephone, using a semi-structured protocol, tailored by type of issuer. The interviews covered health insurance issuer perspectives on five topics: (1) program participation, (2) member outreach and enrollment, (3) provider networks, (4) transitions and continuity of care, and (5) wrap-up and lessons learned.

Findings

1. How and why do health insurance issuers decide whether to participate in the Marketplace, Medicaid, and CHIP?

- Existing commercial, Medicaid, and CHIP issuers chose to offer coverage through the Marketplace because their organizations perceived it to be an exciting business opportunity. Most issuers interviewed decided to participate early on, sometimes before knowing details about how their states would implement their Marketplaces (such as whether they would opt out of the Medicaid expansion, or the type of Marketplace to be offered).
- Issuers offering only Marketplace or Medicaid and CHIP coverage cited a variety of reasons for not participating in the corresponding program, but several are considering participating in the other program in the future.
- Marketplace CO-OP issuers, which were newly created entities serving the Marketplace under the Affordable Care Act, had diverse origins, but their leaders all said a key goal was to offer consumers a new type of affordable insurance option that provided enrollees with a voice in their coverage. None was yet participating in Medicaid or CHIP, but two of the four interviewed reported considering that possibility in the future.
- Of those issuers interviewed that offered coverage across programs, all were existing Medicaid and CHIP issuers that decided to join the Marketplace as a way of benefiting their enrollees and providers, although they recognized that this decision would add some new administrative and operational burdens.

2. How are provider networks developed, and what decisions do issuers make that promote or hinder provider network overlap?

- Provider network development is a concern mainly for Marketplace plans: all of the issuers interviewed that offer Medicaid and CHIP coverage reported that their networks had been established for many years and that, at this point, active provider recruitment was quite limited.
- Those Marketplace issuers interviewed that existed prior to the start of the Marketplace reported that they developed provider networks by modifying existing commercial or Medicaid and CHIP networks. Among the newly created CO-OP issuers, all reported leasing or modifying networks from other sources or partnering with a Medicaid and CHIP network to help leverage relations.
- Issuers generally identified the same gaps in their networks, regardless of product or location; these were caused by provider shortages in particular areas rather than providers being unwilling to participate in networks.
- Issuers with products across programs recognized that offering overlapping networks has many benefits, and that their approach to contracting with providers—whether offering participation in all product networks to all providers or undertaking selective contracting with them—affected the degree of overlap across those networks.

3. How do issuers respond to and perceive those policies having the following aims:**a. Use marketing, outreach, and education to help consumers learn about Marketplace, Medicaid, and CHIP products and programs?**

- Regulations for marketing and outreach to consumers differ across states and program types. Despite these variations, the strategies issuers reported employing are quite similar, and include mass media campaigns, participation in community events and health fairs, and partnering with community providers to raise awareness. Marketing was especially important for CO-OP issuers, due to their status as newly created entities.
- The assistance available to consumers at the point of enrollment appears comparable across programs and locations; it includes Navigators, certified application counselors (CACs), and member services help lines; these services were especially crucial, given the enrollment challenges faced during the first open enrollment period.
- All of the issuers interviewed offer potential enrollees access to provider network directories to help consumers make informed choices when selecting plans, although some noted that consumers need still more information to understand their choices.

b. Set provider network adequacy standards and monitor network compliance?

- The federal government sets Marketplace network adequacy standards, although states have a great deal of flexibility in interpreting the regulations. Issuers must also comply with any state standards that were in place prior to the Affordable Care Act. Issuers perceived the standards to be fairly similar across programs, although some perceived the Medicaid and CHIP network adequacy standards as more straightforward.
- In general, existing Marketplace issuers viewed the standards as relatively lenient; several reported needing to recruit essential community providers (ECPs) to their networks, but otherwise did not struggle to comply. CO-OP issuers reported more challenges, potentially due to the practice of leasing outside networks as well as their status as new issuers.
- Issuers across products use similar processes for internally monitoring network adequacy, including Geoaccess software and in-house tools to monitor enrollee-to-provider ratios. Whereas Medicaid and CHIP issuers were clear about how the state monitored their network adequacy, one Marketplace issuer expressed a lack of understanding about how the state monitored Marketplace network adequacy.
- All Marketplace issuers provide online provider network directories, which are updated frequently—if not daily. Nearly all Medicaid and CHIP issuers in the study also provide online provider network directories.

4. How are systems set up to handle transitions between programs, and what policy mechanisms could help ease disruptions in coverage or care during these transitions?

- Defining program eligibility based on income neatly divides individuals between the Marketplace, Medicaid, and CHIP at any single point in time, but family income and composition evolves, resulting in potential eligibility changes that require individuals to transition across programs

- Policy mechanisms have been enacted to help ease transitions, including continuity-of-care laws and bridge plan legislation. Continuity-of-care laws are important policy mechanisms that help ensure smooth transitions for individuals with serious medical needs; issuers reported that they were in compliance with these laws. California is the only state in our study currently considering bridge plan legislation, and issuers were uncertain about this approach.
- Issuers were aware of potential problems with transitions across programs and, although they could speak only hypothetically about them, they expressed concerns about both the negative consequences for enrollees, providers, and their own firms. To ease transitions for enrollees, some issuers are taking steps to encourage consumers to stay with the same issuer when transitioning or otherwise make informed decisions that would enable them to maximize continuity of care.
- By virtue of the way the programs are designed and administered, issuers—even those participating in multiple programs—currently treat the programs relatively distinctly.

5. What major lessons did issuers learn during the first open enrollment period, and how are those lessons influencing their future planning?

- Marketplace issuers gained insight into consumer behavior and decision-making processes during the first open enrollment period, but some drew different conclusions about the importance of price and provider choice. All of them entered the first open enrollment period thinking that “price was king”—some issuers found this assumption validated, whereas others were surprised at the number of consumers who appeared to make their selection based on brand, quality, or other factors.
- Despite the multipronged outreach strategies in anticipation of and during the first open enrollment period, issuers reported that gaps in consumer and provider education remain.
- None of the issuers interviewed reported plans to leave the Marketplace, Medicaid, or CHIP in future years. In fact, five of the eight Marketplace-only and four of the six Medicaid- and CHIP-only issuers reported considering entering the corresponding program at some time in the future, although not in the upcoming year.
- For the 2015 plan year, Marketplace issuers reported making changes to product design and premiums in response to lessons learned during the first open enrollment.

Conclusions

Decisions issuers make in response to the Affordable Care Act and subsequent regulations—such as whether to offer coverage through the Marketplace, Medicaid, or CHIP; what plans to offer; how to build provider networks; and the cost of premiums—are critical to whether the law will maximize coverage and offer previously uninsured or underinsured individuals access to high quality coverage. Individuals at the margins of eligibility for the Marketplace (those nearest 138 percent of the federal poverty level) are expected to transition frequently between Marketplace and Medicaid/CHIP eligibility, and the choices issuers make will affect the ease of transition for these individuals. Decisions made by individuals also affect their ability to transition smoothly across programs, such as the issuer and policy they select initially, whether they understand how to use their coverage to obtain care when needed, and learning how to

maintain their insurance coverage and providers when income or family circumstances change. Most issuers we interviewed recognized and voiced concerns about continuity-of-care issues at the point of transition, but said it was too early for many enrollees to have transitioned across programs. During the next year, millions of people are expected to transition between the Marketplace and Medicaid/CHIP, meaning monitoring the transition processes and subsequent effects on continuity of care will be of critical importance.

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I. INTRODUCTION

A. Rationale for this study

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) ushered in a new era of health insurance coverage, including the establishment of a wider range of health insurance products than previously was available or accessible to uninsured or underinsured Americans. The Affordable Care Act established new health insurance Marketplaces where individuals can purchase government-regulated, standardized health care policies, with federal subsidies available to offset premium costs for those with household incomes between 100 and 400 percent of the federal poverty level (P.L. 111-148, Section 1311; Section 1401). The law also expanded Medicaid eligibility to all nonelderly citizens and eligible legal residents with household incomes below 138 percent of the federal poverty level (133 percent, with a 5 percent disregard [P.L. 111-148, Section 2001]), dependent on states opting in to the Medicaid expansion.¹ Many of these new products are available for people at all income levels; however, they are especially critical for lower-income individuals and families. Many people previously unable to afford or qualify for coverage in the individual market, as well as those previously eligible but not enrolled in public coverage, may now gain coverage for the first time.

Many aspects of the Marketplace must coordinate with public coverage programs (Medicaid and the Children's Health Insurance Program [CHIP]); for example, they must utilize a one-stop shopping application portal for enrollment. Because these programs usually are administered separately, however, the possibility of discontinuous coverage exists when people transition across programs. For example, each program may contract with health insurance issuers separately for health plans, meaning the brand options available across programs may differ, and the programs offer different levels of benefits and cost-sharing.² The Affordable Care Act includes no requirement that issuers in one program also participate in another, and issuers are presumably making decisions that best reflect their business interests and corporate strategies.^{3,4,5}

¹ In *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court ruled that states cannot be forced to participate in the Medicaid expansion under penalty of losing their current Medicaid funding. As of September 14, 2014, 27 states and the District of Columbia had chosen to expand Medicaid, and 23 had chosen not to do so (Kaiser Family Foundation 2014).

² Some states conduct joint purchasing (sometimes referred to as joint contracting) for Medicaid and CHIP, which standardizes the process by which issuers can participate in these programs.

³ Even if they want to participate in Medicaid and/or CHIP, Marketplace issuers also could be limited in doing so in the short term if the state Medicaid and/or CHIP managed care programs are not immediately open to new issuers.

⁴ Although the Affordable Care Act does not require issuers in one program to participate in the other, states are permitted to institute policies that ease the transition burden. For example, Nevada offers those losing Medicaid coverage the option to purchase one of two Transition Plans, which are Marketplace plans offered by Medicaid issuers utilizing the same Medicaid provider network (Silver State Health Insurance Exchange 2013).

⁵ Although not addressed in this report, individuals and families in states that opted out of the Medicaid expansion will be faced with a different set of problems: changes in income or family circumstances will lead to some losing Medicaid eligibility even while earning too little to qualify for subsidies to purchase coverage through the Marketplace (or vice versa), causing a potential gap in coverage.

Although it is too early to know exactly how many people will be affected by eligibility changes requiring them to transition across programs, a recent study using national survey data estimated that nearly one-third of all adults with family incomes below 400 percent of the federal poverty level would experience a shift in eligibility from Medicaid or CHIP to a Marketplace plan (or vice versa) within six months (Sommers et al. 2014). Furthermore, the researchers anticipated that half of adults with family incomes below 400 percent of the federal poverty level would change their eligibility status within a year.

Frequent transitions between programs create issues such as the following for all stakeholders, including health insurance issuers, providers, and the individuals and families undergoing the transition:

- Health insurance issuers may face significant turnover among enrollees, potentially higher administrative costs, and a less stable risk pool if many of their enrollees frequently transition in and out of coverage.
- Providers may lose patients when people shift between programs and are no longer covered by a product that allows them to see the same provider.
- Individuals and families will likely face different cost-sharing responsibilities when they transition, new or different plan requirements, and the administrative burden of transitioning between programs.⁶ They may lose coverage from their provider if the provider does not participate in the new network they select.
- Transitions may be especially problematic for individuals with special health care needs or those undergoing a specific course of treatment, since provider and coverage continuity are of particular importance in such circumstances.

This report focuses on one aspect of transitions: continuity of care—the ability of an individual to keep the same providers when transitioning between programs. The two main drivers affecting a person’s continuity of care at the point of transition are (1) health insurance issuers’ decisions made in response to the options and policies put forward in the Affordable Care Act or about provider networks in general, and (2) individuals’ purchasing decisions made at the point of enrollment and transition. For health insurance issuers, the decision to participate in the Marketplace, Medicaid, or CHIP in a particular market area is a calculation based on the size of the potential membership market, whether they want to cover the population purchasing insurance through a particular program, and the types of administrative and financial requirements they must satisfy to participate. Once deciding to participate in a particular program, the health insurance issuer determines how best to differentiate its products from those offered by other issuers; this can be done by offering access to different networks of providers, exceptional member services, or competitive pricing in the Marketplace. These issuer decisions are also facilitated by policy. This report, focusing on issuer interviews, aims to describe how

⁶ It is important to note that the concept of transitioning between programs, although described here as potentially problematic, is a byproduct of expanded coverage options and an improvement upon the previous situation. Prior to the Affordable Care Act, individuals and families no longer eligible for Medicaid would more than likely become uninsured. Now they are able to purchase affordable insurance through the Marketplace with the use of subsidies.

issuers make these decisions, as well as how they meet government requirements and perceive policy as facilitating choices and smoothing transitions.

The decisions health insurance issuers make in responding to the Affordable Care Act affect individuals' options regarding their insurance selections and how smooth a transition may feel. How individuals respond to the choices presented in the Marketplace, Medicaid, or CHIP programs is also critical to the likelihood of their experiencing continuity of care at the point of transition. A number of factors will affect their ability to transition smoothly across programs, including which issuer and policy they select initially, understanding how to use their coverage to obtain care when needed, and learning how to maintain their insurance coverage and providers when income or family circumstances change. A consumer survey conducted in April 2014 found that more than 25 percent of people purchasing plans through the Marketplace were unaware of the network type (i.e., ultra-narrow, narrow, broad, etc.) they had selected (McKinsey Center for U.S. Health System Reform 2014). If consumers are not sure whether they have purchased a product that offers access to a broad or narrow network—or even whether a network is used, and what that means—they may have trouble understanding care choices and how to make informed decisions in the future.

Very limited research has been conducted aimed at understanding issuers' decisions when responding to the Affordable Care Act and how those decisions may affect continuity of care, mainly because the Marketplace program is new, but also because continuity of care is not easily measured. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services (HHS) commissioned a study conducted by Mathematica Policy Research to examine the degree of provider network overlap across the Marketplace, Medicaid, and CHIP. In that study, we examined the primary care physician networks offered through these three programs in six diverse market areas and assessed the extent to which these networks overlapped as of January/February 2014 (Orfield et al. 2014). We found the following:

- Over a third of all primary care physicians who partake in the programs we studied participate in at least one Marketplace and one Medicaid and CHIP network. This means patients of these primary care physicians who need to change programs will be able to find at least one network within their new program in which their primary care physicians participate.
- About one-half to two-thirds of primary care physicians who participate in a Marketplace network also participate in a Medicaid and CHIP network. A greater share (more than two-thirds) of primary care physicians participating in a Medicaid and CHIP network also participate in a Marketplace network, suggesting that it likely will be easier for consumers to maintain their primary care physicians when moving from Medicaid or CHIP to the Marketplace than when undertaking the opposite transition.
- The issuers offering Medicaid and CHIP coverage were identical in the market areas we assessed, and the primary care physicians participating in their networks are nearly identical, meaning that consumers can make transitions between Medicaid and CHIP without disrupting primary care coverage.

- Maintaining the same health insurance issuer at the point of transition is likely to make it easier for consumers to maintain primary care physicians. However, it is not a guarantee, as the respective networks for the Marketplace and Medicaid and CHIP within the same issuer are not identical.
- Gathering and comparing primary care physician network information both within and across health insurance issuers and among the Marketplace, Medicaid, and CHIP is challenging and would be difficult to accomplish for a consumer having limited understanding of health care choices, computer skills, or access to technology.

B. Purpose of this report

The purpose of this follow-up study was to understand health insurance issuer program participation decisions, how they develop and monitor Marketplace, Medicaid, and CHIP provider networks, how patterns of provider overlap across networks emerge, their perceptions of federal and state regulations, and the types of systems and processes that are set-up to handle cross-program transitions and continuity of care. Using the same sample frame as the previous provider network analysis study, we conducted a series of interviews with health insurance issuer staff in the same market areas to help us understand these topics, as well as to reflect on major lessons learned during the first year of the Marketplace.

The purpose of this report is to answer the following five research questions:

1. How and why do health insurance issuers decide whether to participate in the Marketplace, Medicaid, and CHIP?
2. How are provider networks developed, and what decisions do issuers make that promote or hinder provider network overlap?
3. How do issuers respond to and perceive those policies having the following aims:
 - a. Use marketing, outreach, and education to help consumers learn about Marketplace, Medicaid, and CHIP products and programs?
 - b. Set provider network adequacy standards and monitor network compliance?
4. How are systems set up to handle transitions between programs, and what policy mechanisms could help ease disruptions in coverage or care during these transitions?
5. What major lessons did issuers learn during the first open enrollment period, and how are those lessons influencing their future planning?

C. Overview of methods and data sources

Our study focused on the same six market areas we used in our previous study of provider networks: Chicago, Illinois; Phoenix, Arizona; Louisville, Kentucky; Baltimore, Maryland; Buffalo, New York; and East Los Angeles, California.⁷ As discussed in the report on that study,

⁷ Unless otherwise noted, the market areas are listed in order of population size throughout this report.

market areas were selected to represent a set of locations that vary in characteristics that might be expected to affect the continuity of care an enrollee would experience when switching among Marketplace, Medicaid, or CHIP coverage. They are not intended to be a nationally representative sample.

For the current study, we used the network overlap data to split issuers identified in the previous study into the following five unique categories, based on program participation: (1) Marketplace-only issuers (excluding Consumer Operated and Oriented Plans (CO-OPs)); (2) Marketplace-only CO-OP issuers;⁸ (3) Medicaid- and CHIP-only issuers; (4) Marketplace, Medicaid, and CHIP issuers with high-integration networks; and (5) Marketplace, Medicaid, and CHIP issuers with low-integration networks. We developed semi-structured interview protocols to conduct interviews and elicit different information from the various types of issuers, using input from a variety of individuals with expertise in Marketplace, Medicaid, and CHIP policy.

We conducted issuer recruitment starting in April 2014 and interviewed issuers from May through July 2014. We aimed to interview 36 issuers and invited 44; 18 ultimately participated in the study. Because of the relatively small number of issuers interviewed and potential biases in response (such as the low number of Marketplace, Medicaid, and CHIP issuers with high-integration networks participating), the study is not meant to answer all questions related to the topic of continuity of care, but rather to provide insights into issuers' decision-making processes and perceptions of federal and state policies. As with most descriptive studies, it also is not intended to be comprehensive or nationally representative.

The remainder of this report is laid out as follows: in Chapter II, we describe the data collection and analysis processes; in Chapter III, we discuss program participation decisions and the application process; in Chapter IV, we describe how provider networks are developed and how they overlap; in Chapter V, we discuss policies and issuers' perceptions of member outreach and enrollment; in Chapter VI, we report on network adequacy policies and issuers' perceptions of those policies; in Chapter VII, we report on the transition process and continuity of care policy mechanisms; in Chapter VIII, we report on lessons learned and anticipated changes in the coming years; and in Chapter XI, we summarize the main findings and offer some concluding remarks.

⁸ None of the CO-OPs are participating in Medicaid/CHIP at this time, though some may choose to participate in the future, as we discuss later.

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II. DATA COLLECTION AND ANALYSIS

The purpose of this report is to add context to the provider network analysis completed for the previous report and to provide insights into the behavior of health insurance issuers immediately following implementation of the Affordable Care Act. In this chapter, we briefly review the methodology we originally used to select the six market areas of interest: Chicago, Illinois; Phoenix, Arizona; Louisville, Kentucky; Baltimore, Maryland; Buffalo, New York; and East Los Angeles, California. We then discuss the ways we used the information developed through that study to select issuers to interview, and to inform the recruitment process. We also discuss the development of semi-structured interview protocols and the methods used for analyzing the qualitative data.

A. Original study market area selections

Our original study sought to choose a set of six locations varying in characteristics that might be expected to affect the continuity of care an enrollee would experience when switching among Marketplace, Medicaid, and/or CHIP coverage.⁹ We developed a preliminary selection methodology based on input from several Mathematica subject matter experts and a review of recent publications about the Marketplaces, Medicaid, and CHIP.¹⁰ We presented this preliminary methodology to ASPE in November 2013 and received input to guide the final selection process, which was completed in December 2013.

We began by looking at state-level characteristics and selected six eligible states to include in the study. To be eligible for inclusion, states needed to meet the following four conditions: (1) chose to expand Medicaid, (2) have a significant Medicaid managed care penetration, (3) have a relatively large number of people who would potentially make transitions across Marketplace, Medicaid, and CHIP programs, and (4) lack of technical issues with the online provider directories. We also considered variety in census region, Marketplace design, and Medicaid and CHIP program characteristics.

Once we had selected the six states, we surveyed their five most heavily populated market areas according to a number of characteristics and criteria, such as size of the population, number of geographic rating areas, average Marketplace premiums, and competitiveness in individual insurance markets. In all but two states, we selected the most populous market area. Our analysis for this study revealed that, although Medicaid and CHIP are distinct programs serving different populations, the same set of issuers participates in both programs in the six market areas of interest and offer nearly identical provider networks. With the issuers and networks being the same for all practical purposes, in the remainder of this report we refer to Medicaid/CHIP as a combined unit to simplify analysis and discussion.

⁹ The sample size of six was determined by available resources. The market areas selected are not meant to constitute a nationally representative sample.

¹⁰ For a more detailed description of the market area selection process, please refer to Chapter II of Orfield et al. (2014).

B. Methods for selecting issuers to interview for this study

In our earlier study, we identified and included 48 issuers offering health insurance products through the Marketplace and Medicaid/CHIP within the six market areas as of January/February 2014.¹¹ We used these 48 issuers as the population from which to draw interviewees for this study. Appendix Table A.1 includes descriptive characteristics of the 48 health insurance issuers included in the provider network analysis.

Using data collected during the provider network analysis study, we divided the 48 issuers into five separate groups according to the products they offered and, if they offered multiple products, the level of integration identified across provider networks. We separated Marketplace-only issuers into non-CO-OP and CO-OP groups because CO-OP issuers are new to the health insurance landscape and, due to their structure and formation, had unique perspectives and issues to share. To define the categories for high- and low-integration networks, we calculated the percentage of primary care physicians (defined as family, general, and internal medicine physicians and pediatricians) who participate across both programs for each health insurance issuer. Among the 13 issuers that participate in both programs, the average provider network overlap across these programs was 59.5 percent. We defined “high-integration networks” as those issuers with greater than average overlap and “low-integration networks” as those with less than average overlap. These two groups are quite distinct; the high-integration group ranges from a 76.7 percent to 100 percent overlap, and the low integration group ranges from a 25.0 percent to 56.9 percent overlap.¹²

Of the 48 health insurance issuers in the network overlap study sample, we aimed to interview 36 (Table II.1). In some categories, we targeted as many as 9 issuers per protocol, although several of the categories of issuers had fewer than 9 potential target firms. In categories with fewer than 9, we aimed to recruit all issuers in the category. In categories that had some choice in issuers (Marketplace-only [non-CO-OP] and Medicaid/CHIP-only), we stratified the sample based on market area and issuer’s market share to determine which to recruit.

¹¹ A total of 54 issuers were identified as participating across all market areas. From this set of 54, we excluded 6 due to lack of data for analysis or because they serve a very limited population. In Baltimore, we excluded one Medicaid/CHIP issuer from the study because we requested the provider directory (available only in hard copy) multiple times but never received it, and we excluded one Marketplace-only issuer because it is based primarily in Washington, DC, with only 8 physicians in the Baltimore area. In East Los Angeles, we excluded 3 Medicaid/CHIP issuers because they serve very specific populations (Program of All-Inclusive Care for the Elderly [PACE] and Medicare-Medicaid dual eligibles only). We excluded 2 other Medicaid/CHIP issuers from East Los Angeles because they did not have any physicians located in the ZIP codes of interest (although one remained as a Marketplace-only issuer).

¹² Although each issuer was categorized in a particular group, some interviewees were able to speak to a broader range of topics than specified in that group’s protocol. For example, we spoke with one Medicaid/CHIP issuer that was working to develop a Marketplace product and thus could speak to some issues related to integration, since these issues were at the forefront of the interviewee’s mind.

Table II.1. Number of issuers targeted for interviews and participating in study

	Total issuers	Issuers targeted for interviews	Issuers invited for interviews	Issuers participating in interviews	Percentage of targeted issuers participating
Number of issuers	48	36	44	18	50.0
Marketplace-only (non-CO-OP)	13	9	13	4	44.4
Marketplace-only (CO-OP)	5	5	5	4	80.0
Medicaid/CHIP-only	17	9	13	6	66.7
Marketplace and Medicaid/CHIP with high integration	6	6	6	1	16.7
Marketplace and Medicaid/CHIP with low integration	7	7	7	3	42.9

Source: Mathematica tracking of interview targets (April to July 2014).

Note: The market areas are listed in order of population size. CHIP = Children's Health Insurance Program.

C. Issuer recruitment

Starting in April 2014, Mathematica staff recruited issuers to participate. We conducted interviews with 18 health insurance issuers from May through July 2014. We began identifying potential informants by using two contact lists from health plan directories (American Association of Health Plans 2000; Atlantic Information Services, Inc. 2013). We used each of the resources to identify the network director or network executive position for the targeted issuers. If the directories did not include the issuer or list a network director or network executive, we used the issuer's website and consumer assistance line to identify the appropriate informant.

We reached out to the identified individual via email and phone over the course of several months (April–July 2014; interviews were conducting starting in May). Often we were referred to a different person at the firm. To maximize the response rate, we tried several additional tactics, including sending a letter to issuers from Arnold M. Epstein, Deputy Assistant Secretary for Planning and Evaluation, requesting their participation; offering a briefer interview time (30 minutes rather than the full 60 minutes); and offering to speak with informants during nonwork hours. We also reached out to Mathematica resources for direct contacts at the issuers we had identified, ASPE contacts, and individuals at America's Health Insurance Plans to try to encourage participation.

To interview our target of 36 issuers, we over-recruited by inviting 44 issuers to participate (Table II.1 shows the number of issuers targeted, invited to participate, and participation rates, by protocol category). Eighteen issuers participated in the study; 16 declined to participate; and 10 did not respond to our requests, despite active recruitment. We contacted all Marketplace-only (non-CO-OP) and Marketplace-only (CO-OP) issuers, as well as all those participating in both programs. We contacted all but 4 Medicaid/CHIP-only issuers. Reasons for nonparticipation

reported by issuers included the fact that the process for developing provider networks may be sensitive, they had company policies mandating against communication with research institutions, and key informants lacked the time to be interviewed.

This is a small descriptive study with several important limitations. First and foremost, the results represent only the responses of issuers in the six market areas we investigated and may not be generally applicable to other market areas. Second, we did not achieve full participation; thus, the informants who spoke to us may not represent the experience of all Marketplace and Medicaid/CHIP issuers in the six market areas of interest. Of those not responding, there are no obvious concerns with nonresponse bias (such as only hearing the perspective of large, national issuers, or failing to recruit nonprofit issuers). However, as shown in Table II.1, we struggled to recruit issuers with high-integration networks, which limits discussions of their perspectives on network integration.

D. Protocol development

In early 2014, we engaged an internal team with expertise in the Marketplaces, Medicaid, and CHIP to develop semi-structured interview protocols. Staff from ASPE, which oversees this evaluation, also provided input and advice. We developed the protocols to ensure that we collected information systematically and consistently across market areas, issuer types, and interviewers. In total, we developed five different protocols and tailored them to the five types of health insurance issuers included in the evaluation. We conducted background research on each issuer from publicly-available sources and customized the protocol before each interview. The background information table and five protocols are included in Appendix B. The major topic areas remained the same across the five protocols, and included the following:

- Program participation
- Member outreach and enrollment
- Provider networks
- Transitions and continuity of care
- Wrap-up and lessons learned

Within those topic areas, we modified questions to target those issues unique to that protocol group based either on the programs in which they were participating or their history. For instance, the protocol for Medicaid/CHIP-only issuers included specific questions about whether the company would consider participating in the Marketplace in the future, and what incentives might encourage them to participate. We asked those issuers participating in both programs with high-integration networks questions about whether this degree of integration was intentional and what factors may have contributed to this level of integration.

E. Data collection and analysis

Two team members conducted each interview by phone: a lead interviewer, who asked questions as outlined in the protocol, and a notetaker, who digitally recorded the interview (if permitted) and took extensive notes during the interview. The interviews were designed to be 60 minutes long but, due to informant time constraints, some interviews were limited to 30 minutes.

For shorter interviews, interviewers prioritized questions ahead of time to gather the most important information during the shorter time period.

At the conclusion of each interview, we cleaned the notes, listening to the digital recording to clarify, if needed, and organized them in a standard style. To develop a qualitative coding scheme, including code names and definitions, the research team identified the main research themes of interest. We applied these codes to all interview notes using Atlas.ti (version 7.1.8), a software tool used to manage and analyze qualitative information. Two individuals coded the data, and another team member reviewed coded data to verify that codes had been applied consistently and further refine the analysis and findings.

During analysis, we categorized and summarized the common responses across issuers to discuss them in this report. Because we asked each type of issuer a different set of questions (based on the separate protocols), we did not ask all of them to comment on each specific question (although we did ask all issuers about something within each topic area). Where applicable, we note the number of issuers relevant to each particular paragraph to clarify how many issuers were asked a relevant question.

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III. PROGRAM PARTICIPATION DECISIONS

Key Findings:

- Existing commercial and Medicaid/CHIP issuers chose to offer coverage through the Marketplace because their organizations perceived it to be an exciting business opportunity. Most issuers interviewed decided to participate early on, sometimes before knowing details about how their states would implement their Marketplaces (such as whether they would opt out of the Medicaid expansion, or the type of Marketplace to be offered).
- Issuers offering only Marketplace or Medicaid/CHIP coverage cited a variety of reasons for not participating in the corresponding program, but several are considering participating in the other program in the future.
- Marketplace CO-OP issuers, which were newly created entities serving the Marketplace under the Affordable Care Act, had diverse origins, but their leaders all said a key goal was to offer consumers a new type of affordable insurance option that provided members with a voice in their coverage. None was yet participating in Medicaid or CHIP, but two of the four interviewed reported considering that possibility in the future.
- Of those issuers interviewed that offered coverage across programs, all were existing Medicaid/CHIP issuers that decided to join the Marketplace as a way of benefiting their members and providers, although they recognized that this decision would add some new administrative and operational burdens.

Issuers must consider many factors when choosing whether to participate in the Marketplace or Medicaid/CHIP, including whether participation is feasible from a competitive business perspective and whether the population served is a group they can cover successfully. However, participation by issuers in both the Marketplace and Medicaid/CHIP has the potential to strengthen continuity of coverage and care for low-income health care consumers: through the provider network directory analysis, we found that 27 percent of issuers in the market areas we studied provide plans in both programs. This overlap in participation can help limit the potentially harmful effects of transitioning between programs by lowering administrative costs for issuers and providers, potentially easing the transition burden for enrollees if they choose to maintain the same issuer, and likely making it easier for enrollees to maintain primary care physicians at the point of transition. In this chapter, Section A discusses the decisions issuers faced when choosing to participate in the Marketplace and Medicaid/CHIP, and Section B discusses issuers' perceived advantages and disadvantages of participating in both, as well as their suggestions to improve participation in each.

A. Marketplace participation decisions

1. Existing commercial and Medicaid/CHIP issuers

Most of the eight existing commercial and Medicaid/CHIP issuers we interviewed that chose to offer coverage through the Marketplace felt it “made sense” to participate, and decided early on to do so, regardless of state Marketplace decisions. Three issuers that had

been offering commercial plans prior to the creation of the Marketplace reported that because of their market share and presence in the state, it made sense from a business perspective to participate in the Marketplace. Two other issuers commented that because the population they served before the creation of the Marketplaces likely would become eligible through the new program, it made sense to participate to maintain this portion of their business. All five of these issuers decided to participate before their respective states had decided what type of Marketplace would be implemented. Only one issuer interviewed was required to participate in the Marketplace (by Maryland law) based on its size and share in the existing commercial market.¹³

As one existing commercial issuer noted about the decision to join the Marketplace, “We couldn’t sit on the sidelines and let our market share diminish as the [Marketplaces] opened up; there was too much at stake.”

Several Marketplace issuers identified problems with the Marketplace application process and suggested ideas for improvement. Three issuers noted that the time frame to apply was relatively short, given the newness of the Marketplaces and how much work had to be accomplished prior to submission. One commented that “[In 2014], we definitely had issues with quick turnaround times and process[es] that were kind of evolving as we went.” One issuer also stated that some of the data entry requirements could be improved, citing a series of manual data entry tasks that lacked sophistication and were potentially prone to error. The issuer recommended that the government “...try to come up with a more technically sound method, more automated, with some built-in checks and summaries to show what our data will actually look like” in the future.

The four Marketplace-only issuers that had commercial plans before the creation of the Marketplace cited reasons for not participating in Medicaid/CHIP, such as concerns with the Medicaid expansion implementation. One issuer noted that problems with its state Medicaid expansion were a concern in entering the program initially, since “it was brand new ... and was rolled out very quickly.” Another had established previously that it would not participate in Medicaid/CHIP, although this issuer noted that it is reconsidering this decision and currently is looking into entering the program to offer consumers an alternative, not-for-profit Medicaid/CHIP option. Additionally, one issuer currently participates as a subcontractor to a Medicaid/CHIP issuer but would prefer to contract directly with the state at some point in the future.

Likewise, the six Medicaid/CHIP-only issuers did not participate in the Marketplaces for a variety of reasons, including concerns about the unknown risks and “potential headaches.” The reason three issuers cited for not participating in the Marketplaces was that they felt there were too many unknowns and were hesitant to assume the corresponding risks. Instead, they chose to “wait and see” how the Marketplaces would settle after a full year of operation. One of these three reported that it had already applied for and been accepted as a Marketplace qualified health plan (QHP) issuer for 2015, and another “...would consider

¹³ Maryland requires issuers within the same holding company and collectively reporting either \$10 million in aggregate annual earned premiums in the individual market or \$20 million in small group markets outside of the Marketplace to offer plans in the state’s Marketplace if they offer plans outside of the Marketplace (Maryland Health Benefit Exchange 2013). New York encouraged issuers to participate in its Marketplace by prohibiting them from entering it for up to two years if they did not participate in 2014 (Dash et al. 2013).

participating if someone approached us; for example, if a provider group approached us about sharing risks ... or if someone offered capital or capabilities.”

Two other issuers were established specifically as Medicaid/CHIP plans and had no commercial offerings; one of them did express interest in participating in the Marketplace, but it was a relatively new issuer and did not have the resources to create additional offerings at that time. Similarly, another issuer had devoted resources to creating other offerings in Medicare and its state’s Medicaid expansion, and could not allocate enough additional resources to create the additional plans they would have needed to participate in the state’s Marketplace: “The idea of taking on one more thing in this first year did not make a ton of sense.”

2. New Marketplace CO-OP issuers

Section 1332 of the Affordable Care Act directed the Centers for Medicare and Medicaid Services (CMS) to establish the CO-OP program. This program provides low-interest loans to eligible nonprofit groups to set up and maintain nonprofit QHPs, which are directed by their customers and designed to offer affordable, consumer-friendly, and high quality health insurance options. CO-OP loans are made only to those private, nonprofit entities that demonstrate a high probability of financial viability (CCIIO 2014a). Four of the Marketplace issuers we interviewed were created in response to the Affordable Care Act mandate to offer CO-OPs.

Each of the four CO-OP issuers we interviewed emerged from a different starting point, but all were created with the common goal of offering affordable insurance. Two individuals started two of the CO-OPs, championing the effort and viewing it as a means of creating alternative offerings in the Marketplace that would enhance the quality of choices and offer enrollees a stake in their health insurance. One of the CO-OP interviewees indicated that “When the Affordable Care Act was passed, [the person starting our CO-OP] decided that he wanted to open a different type of HMO on the [Marketplace] to ensure that the millions of uninsured had access to care.” The other issuer’s designer thought that creating a CO-OP could have some of the same benefits as a single-payer system and enlisted others to assist in its creation in that state. Sponsoring organizations started the other two: in one case, a hospital association believed it had the competencies to allow for and support the creation of the CO-OP; the other, a local union, had been advocating for the rights of underrepresented Americans (though the CO-OP has since become independent from the union).

Since each of the CO-OP issuers were new insurance entities created to participate in the Marketplace, none had the bandwidth to participate in Medicaid/CHIP during their first year of operation. Two of the CO-OPs have considered offering Medicaid/CHIP coverage in the future, though this may take time. Both set a target time frame of three years before considering expansion into those areas, and one has formed a partnership with a Medicaid/CHIP plan to ease transitions between programs. Another CO-OP, though wanting to expand so as to help with continuity of care, has not considered entering Medicaid/CHIP because it does not have enough capital. The last CO-OP has not considered expanding and does not have any immediate plans to do so.

B. Participation in both Marketplace and Medicaid/CHIP

The four issuers participating in both the Marketplace and Medicaid/CHIP believe their participation in both is an advantage for enrollees who may transition across programs, as well as their providers. All four issuers we interviewed that participated in both programs felt they provided an important advantage—the ability to ease the burden on both individuals transitioning between Marketplace and Medicaid/CHIP eligibility and their providers. One issuer also pointed out that its participation in multiple programs might help with member loyalty and hoped individuals would recognize the advantages of an issuer offering

One issuer offering both Marketplace and Medicaid/CHIP coverage reported, “I think we do see and expect to see more [issuer] allegiance by members as they shift among products. I think it will also definitely help providers to have that continuity on the payer side to help facilitate those transitions.”

coverage through both programs. In addition, issuers thought that maintaining individuals’ continuity of care as they move between programs was an advantage because it leads to fewer disruptions in medical care and offers them more continuous access to preventative services, thus potentially eliminating costly future medical bills.

Though these four issuers cited advantages in participating in both programs, they also noted increased administrative and operational burden.

One issuer noted that, due to the relatively small Marketplace enrollment, participating in both programs could lead to inefficiencies, as the potential for providers having smaller panels would create a higher proportion of administrative burden for both providers and issuers. Another issuer commented that the resources required to develop Marketplace plans could be a disadvantage to smaller issuers: “That financial commitment to get off the ground is huge. Once [the infrastructure is] built, the maintenance won’t be so bad, but it’s a big initial investment to make.” However, one issuer felt that there were no disadvantages to participating in both programs and observed that “...some of the cynics are having a change of heart because they’re seeing that more people are getting care.”

None of the states covering these six market areas offer incentives to encourage Marketplace issuers to participate in Medicaid/CHIP, or vice versa, but several of the issuers we interviewed offered suggestions for improving participation in both programs.

Because the previous provider network study found a strong correlation between issuer participation across programs and primary care physician participation across programs, we asked issuers for ideas about incentives that could potentially encourage broader cross-program participation. Two issuers suggested that offering financial incentives tied to metrics, including increased reach and performance metrics in addition to quality, such as operational and administrative performance, could help boost issuer participation in both programs. Another issuer felt that a longer contract period could entice more issuers to offer Marketplace coverage, rather than the reported 18-month period with three potential one-year extensions. One issuer suggested simply requiring Medicaid/CHIP issuers to offer products in the Marketplace: “I believe strongly that the Medicaid plans are best positioned to manage [the Marketplace population] because they are already familiar with them.” Two Medicaid/CHIP issuers, on the other hand, felt there was no need for the state to encourage participation in their state’s respective Medicaid/CHIP programs, as there is already enough competition in them.

 IV. PROVIDER NETWORK DEVELOPMENT AND OVERLAP

Key Findings:

- Provider network development is a concern mainly for Marketplace plans: all of the issuers interviewed that offer Medicaid/CHIP coverage reported that their networks had been established for many years and that, at this point, active provider recruitment was quite limited.
- Those Marketplace issuers interviewed that existed prior to the start of the Marketplace reported that they developed provider networks by modifying existing commercial or Medicaid/CHIP networks. Among the newly created CO-OP issuers, all reported leasing or modifying networks from other sources or partnering with a Medicaid/CHIP network to help leverage relations.
- Issuers generally identified the same gaps in their networks, regardless of product or location; these were caused by provider shortages in particular areas rather than providers being unwilling to participate in networks.
- Issuers with products across programs recognized that offering overlapping networks has many benefits, and that their approach to contracting with providers—whether offering participation in all product networks to all providers or undertaking selective contracting with them—affected the degree of overlap across those networks.

The degree to which individuals transitioning between health insurance products can maintain continuity of care is determined by the degree to which those provider networks offered by health insurance issuers overlap across different programs. For example, if an individual's primary care physician participates in networks associated with both the Marketplace and Medicaid/CHIP, moving between programs due to a change in economic or family circumstances potentially will be less disruptive than for someone whose primary care physician does not participate in both programs and thus will need to find a new one. In this chapter, we discuss how issuers developed their provider networks (Section A), and the broad decisions they made that may have influenced network overlap across programs (Section B). We then focus specifically on issuers that offer both Marketplace and Medicaid/CHIP products, review how integrated those networks are (according to our data), and what decisions these issuers made that may have influenced that level of integration (Section C).

A. Provider network development

During the interviews, we collected information on the approach issuers took when building their provider networks, how they determined which type of network(s) to offer (i.e., a health maintenance organization (HMO) vs. a preferred provider organization (PPO)), and what challenges they faced when recruiting providers to networks. Due to structural differences between programs, issuers are able to offer multiple networks and multiple types of networks

(i.e., HMOs and PPOs) within the Marketplace program, but not within Medicaid/CHIP.¹⁴ Some issuers offer multiple types of networks to provide consumers with cost-competitive choices and multiple price points. Medicaid's (and to a lesser extent, CHIP's) comprehensive benefit requirements and restrictions on out-of-pocket cost-sharing mean that issuers do not offer consumers choices within the program: each offers only one network and one product per market area.

Provider network development is a concern mainly for Marketplace plans: all 10 Medicaid/CHIP issuers interviewed reported that their networks had been established for many years and that, at this point, active provider recruitment was quite limited. Issuers described Medicaid/CHIP networks as in a “regular maintenance” phase, meaning that issuers would only recruit new providers to their network if there was an identified area of network weakness or if one of their members requested that they include a specific provider in their network. Otherwise, issuers would respond to provider requests to join as they received them. Despite not actively recruiting physicians to Medicaid/CHIP networks, some issuers voiced concerns about developing high-performing networks. Providers have negative perceptions about the patient population covered through Medicaid/CHIP and, despite the recent Medicaid reimbursement rate increase, issuers commented that providers know that the rate increases are temporary and may be making network participation decisions based on longer-term expectations.

Of the 12 issuers interviewed that offer Marketplace coverage, 8 already offered commercial or Medicaid/CHIP coverage and used their existing networks as a starting point to create their Marketplace networks. These issuers reported that they had existing relationships with providers that they used to create their Marketplace networks, with some modifications based on network requirements and the types of consumers expected to purchase Marketplace products. For example, issuers building off of existing commercial networks said they generally needed to add safety net providers (also known as essential community providers [ECPs]) to the networks to comply with Marketplace network adequacy standards (network adequacy standards are discussed further in Chapter VI). Further, they expected consumers purchasing Marketplace products to differ from those previously purchasing employer-sponsored insurance or commercial coverage through the individual market; they speculated that these consumers might have more pent-up demand for health care services if they previously had been uninsured or underinsured, and issuers expected them to have lower incomes than their traditional enrollees. Some issuers said they modified existing networks to offer a lower-priced product with a

A Marketplace issuer that created a narrow network offering said, “Through advice from consultants and internal consensus, we decided on a product that had a slightly narrower hospital offering for pricing purposes . . . We chose [providers] based on cost effectiveness, relationships, areas covered, and related things.”

¹⁴ A small number of issuers in this study also offer point-of-service (POS) plans and exclusive provider organizations (EPOs). POS plans require members to obtain services through a primary care provider (or “point of service”) but offer a limited reimbursement for some out-of-network services. For analysis purposes, POS plans (which were only offered in the Baltimore and Buffalo Marketplaces) are categorized as HMO plans because they operate like HMO plans. EPO plans are identical to PPOs, except that no reimbursement is given for out-of-network care; EPOs are only offered in Buffalo's Marketplace and, for analysis purposes, are categorized as PPOs.

narrow network to attract price-conscious shoppers, focusing on providers perceived as “high value” or “cost-efficient.”

In addition to the issuer having a choice in determining which providers to include in its networks (as long as they complied with network adequacy standards), providers also have a choice in the networks in which they participate, and not all of them were interested in participating in a new product for the untested Marketplace. For example, one existing commercial issuer reported that it invited all physicians participating across its commercial product lines to participate in its Marketplace network, and approximately 60 percent accepted this initial offer. Now that the Marketplace is seen as a viable entity in that state, however, the issuer is receiving ongoing requests from physicians who did not choose to participate from the outset who now want to amend their contracts. “We have ongoing requests from physicians wanting to participate now that did not want to participate initially. We have an open door, provided that they meet our requirements.” Beyond uncertainty about the Marketplace’s viability, another issuer commented that not all providers are interested in participating in Marketplace HMO networks because they are liable for a larger degree of financial and administrative risks than under a PPO configuration.

The four Marketplace issuers that did not offer existing coverage were all newly created CO-OP issuers that did not have existing networks to leverage and thus leaned heavily on leasing networks from other sources to meet the demanding time lines at start-up. CO-OPs had little time between receiving authorization to form a new firm and the deadline for submitting the QHP application, and many viewed leasing an existing network as the most efficient use of limited resources. Three of the four CO-OP issuers interviewed leased networks from existing commercial or Medicaid/CHIP issuers, at least temporarily, to get their products off the ground quickly. Two issuers specifically noted that leasing another issuer’s network was a short-term solution and that they were in the process of building their own proprietary networks for the future. The one CO-OP issuer that did not lease an existing network reported that it partnered heavily with an existing Medicaid/CHIP issuer, leveraging those relationships to build a new network quickly.

Although these issuers saw leasing networks as a necessary means of getting their products off the ground for the initial open enrollment period, they found that this was not always a seamless process. One issuer noted some problems with the approach from a provider perspective. It had leased networks from two different sources and said that, although consumers did not feel the presence of two separate networks, it was sometimes confusing for providers. Some providers had negotiated one reimbursement rate through one network and a different reimbursement rate through the other, so billing for two different networks at times proved challenging. Issuers also viewed the limited control they had when leasing networks as a drawback and said this is one reason for trying to build their own proprietary networks—to have greater control over provider choices, contracts, reimbursement rates, and other matters in the future.

Marketplace issuers tend not to differentiate networks based on metal level, although they reported hearing providers express some concern about participating at all metal levels. Of the 12 Marketplace issuers interviewed, all but one reported that they did not differentiate provider networks by metal level so as to ease administrative burden (this finding is

consistent with our previous network analysis). The one issuer that did differentiate based on metal level reported that it had general products available at all metal levels as well as a set of additional products (with a very limited network) available only at certain metal levels. Its goal was to offer products at extremely low price points specifically for those previously uninsured who accessed care primarily through ECPs.

At least one issuer indicated that, although it may not differentiate networks based on metal levels, providers do consider these levels and voice concern about participation across all levels. Because they think that most individuals purchasing through the Marketplace may be doing so for the first time, providers are worried that these individuals may not understand the amount of cost-sharing involved in some of the low-cost plans. Thus, some providers were concerned about the degree to which they may be “on the hook” for costs incurred by individuals at lower metallic levels.

As one Marketplace issuer described provider concerns, “There’s a considerable amount of consternation around the patient responsibilities. Providers are naturally leery of the bronze level because there are no subsidies on the patient side, with steep deductibles, and obviously some patients can’t pay those, so the provider takes on that debt.”

Although nearly all Marketplace issuers used existing networks (either their own or leased), issuers actively continued to recruit providers to participate in those Marketplace networks, and several noted recruitment challenges that arose during this process.

Recruiting providers to participate in a network generally includes direct discussion with them, executing new contracts,¹⁵ or amending existing ones. In recruiting for the Marketplace, two issuers commented that some providers were wary of participating in their new networks due to concerns about member uptake and the viability of the Marketplace. Other issuers noted concerns about small patient panel sizes and the needs of the new patient group. Although issuers were required to include ECPs in Marketplace networks, they noted that recruiting such providers to the Marketplace was particularly challenging due to ECPs’ concerns about being able to serve additional populations. Finally, one issuer noted that the credentialing rules are not identical for Medicaid/CHIP and Marketplace providers; this proved to be an additional obstacle for some ECPs when joining Marketplace networks.

Issuers identified similar gaps in their networks, regardless of product or location, which generally were caused by provider shortages in particular areas, rather than providers being unwilling to participate in networks. The gaps issuers identified are fairly common, including those for primary care providers, dermatologists, behavioral health specialists, cardiologists, and pediatric sub-specialties. In these gap areas, issuers mostly felt that the problem was one of provider supply, not of providers being unwilling to participate. “There just aren’t the providers in the area to serve the [more rural] population . . . So, that’s a challenge we have been working through and trying to come up with creative ways within our large

¹⁵ The length of provider contracts was reported to vary by issuer and program, with Marketplace contracts more likely to be shorter term and Medicaid/CHIP contracts more likely to be “evergreen,” meaning they automatically renew unless notice for termination is given. In the Marketplace, the length of provider contracts was reported to vary by product type (HMO vs. PPO) and range from one- to five-year contracts to evergreen. On Medicaid/CHIP, all issuers reported using evergreen contracts except for one, which noted that its provider contracts were one year in length, with an evergreen clause for automatic renewal.

facilities to recruit specialty providers into the area and get them connected where access is an issue.”

B. Network overlap across programs

During the provider network analysis study, we found that more than one-third (37 percent) of primary care physicians in the market areas of interest participated in at least one Marketplace and one Medicaid/CHIP network, meaning that these physicians’ patients who need to transition across programs would be able to find at least one network in their new program that includes their primary care physician.¹⁶ In considering the decisions that may have influenced this overlap rate of 37 percent, in this section we focus on the eight Marketplace-only issuers (including non-CO-OPs and CO-OPs) and how their networks could have been developed to overlap with outside Medicaid/CHIP networks. The focus is on decisions made by Marketplace-only issuers, since all of the Medicaid/CHIP issuers interviewed for this study already had existing networks prior to the implementation of the Marketplace, and none reported making special efforts or new decisions to amend those networks after Affordable Care Act implementation (as reported in Section A). We first discuss choices made by existing commercial issuers that entered the Marketplace space (non-CO-OPs); second, we discuss decisions made by newly created Marketplace-only issuers (CO-OPs).¹⁷

Existing commercial issuers built their Marketplace networks from their existing commercial networks, leading to potentially higher degrees of overlap between Marketplace and commercial networks. Of the four existing Marketplace-only providers interviewed, three issuers noted that their Marketplace networks were built out of products already offered in the commercial space, using their commercial networks as a starting point and refining them to meet network adequacy standards and other specific goals. As discussed in Section A, this could include recruiting additional ECPs or narrowing a commercial network to include only the most efficient or highest quality providers. Whether this approach to building Marketplace networks yields a high degree of overlap with Medicaid/CHIP networks depends on the content of those networks and how much they overlap with other issuers’ Medicaid/CHIP networks; the Marketplace-only issuers we interviewed were not able to comment on this issue.

Newly formed CO-OP issuers leased networks from existing commercial or Medicaid/CHIP issuers; this strategy is most likely to lead to the highest degree of network overlap across programs. Only one CO-OP issuer is leasing a Medicaid/CHIP network directly; the others are leasing commercial networks and thus have the same network overlap status as described in the above paragraph. One issuer currently leasing a commercial product reported that they were partnering with a Medicaid/CHIP issuer to create a new (not offered yet) “continuation of coverage” plan. In this plan, the networks, benefits, and plan designs will be

¹⁶ Excluding Chicago from the calculation increased the overlap rate by about 9 percentage points (to 46 percent) because the volume of physicians in Chicago is so high (and their overlap rate so low) that its inclusion skews the full sample numbers downward. The network overlap rates in four of the six market areas examined (Phoenix, Louisville, Baltimore, and East Los Angeles) were strikingly similar, all falling between 43 and 47 percent. Chicago and Buffalo were outliers, with overlap rates of 25 percent and 65 percent, respectively.

¹⁷ In Section C, we discuss at length the specific decisions and efforts made by issuers offering both Marketplace and Medicaid/CHIP coverage.

streamlined across programs to the extent possible, meaning that people no longer eligible for Medicaid/CHIP could select that Marketplace plan and have access to similar coverage and providers (and vice versa). This partnership developed out of personal relationships among staff at the two issuers and alignment of sponsoring organizations; the stated goal was to create the highest degree of overlap possible.

The one CO-OP Marketplace issuer that did not lease an existing network still utilized Medicaid/CHIP in an interesting way that lent itself well to network overlap. It established strong partnerships with ECPs in the area who recognized that funding streams were changing as a result of the Affordable Care Act. These providers wanted to work closely with a Marketplace issuer so as to know where to refer their existing uninsured patients to ensure they received continuous and appropriate care. Further, this issuer established a relationship with an existing Medicaid/CHIP issuer, which was able to leverage its existing relationships with physicians and physician groups to encourage them to participate in the partner issuer's Marketplace networks.

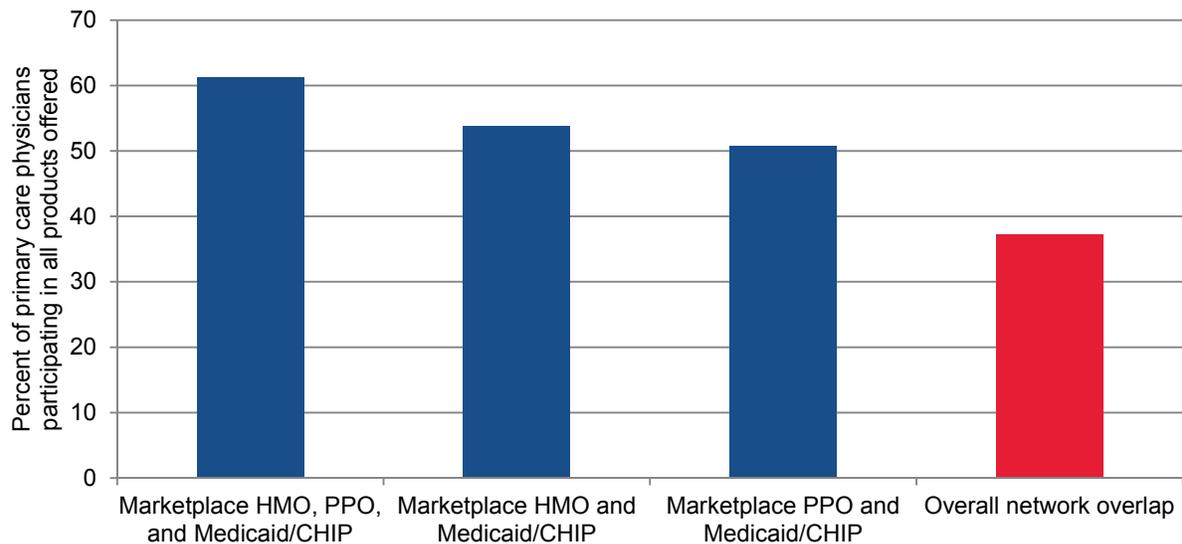
A CO-OP issuer noted, “We were able to partner with that Medicaid provider to present ourselves in conjunction with them [and] . . . leverage that relationship that this Medicaid plan had with those providers. They were able to help us open doors.”

C. Within-issuer provider network overlap across programs

During the provider network analysis, we found that maintaining the same issuer at the point of transition is likely to make it easier for consumers to maintain primary care physicians, although it was not a guarantee because the respective networks for the Marketplace and Medicaid/CHIP within the same issuer are not identical. As shown in Figure IV.1, 61 percent of primary care physicians participate in both programs among issuers offering Marketplace HMO, Marketplace PPO, and Medicaid/CHIP networks. Among those issuers offering Marketplace HMO and Medicaid/CHIP products, 54 percent of primary care physicians participate in both programs. Among issuers offering Marketplace PPO and Medicaid/CHIP products, 51 percent of primary care physicians participate in both programs. This is in comparison to the 37 percent of providers in general who participate in more than one network type.¹⁸

¹⁸ During the interviews, only one issuer (of the four that offer plans in both programs) reported that they conducted a similar type of internal network overlap analysis. In general, issuers recognized the potential benefits of overlap but said that this type of analysis was not something upon which they currently had the resources to focus.

Figure IV.1 Network overlap rates by product(s) offered (%)



Source: Orfield et al. 2014.

Note: The blue columns indicate within-issuer network overlap; the red column indicates general network overlap across all issuers.

Issuers offering products across programs recognize that offering overlapping provider networks has benefits for enrollees and providers, as well as business advantages.

Nearly all issuers that offered coverage in the Marketplace and Medicaid/CHIP told us that the degree of overlap across the different programs' networks was one of their primary concerns when building their Marketplace networks, and that many of the networks were constructed with that concept in mind. From the member's perspective, issuers saw care continuity and the fluidity of the transition as major advantages to having highly integrated networks. Transferring from one program to another comes with a lot of uncertainty and change, and issuers see it is a bonus to enrollees if they know they can keep the same issuer, and most likely have access to the same providers.

An issuer with high-integration networks reported, "From a care continuity perspective, if a member does transfer from one level of coverage to another, there is a higher degree of care continuity. A member doesn't have to look for a new primary care provider or specialist ... they can continue on, typically with their current treatment and routine care."

Several issuers who offered both Marketplace and Medicaid/CHIP products made the business case for offering highly integrated networks, saying that they used this concept (or anticipated using it) as a marketing tool to encourage enrollees to stay with one of their products at the time of transition. If a Marketplace issuer does not offer a corresponding product in Medicaid/CHIP (or vice versa), issuers feared losing individuals at the point of transition and not recouping them if they became eligible for the Marketplace again. As one issuer stated, "If you don't offer an exchange product and a customer moved to the exchange from Medicaid eligibility and got a product with someone else, they're not going to come back to us if they become Medicaid eligible again. We would just be moving our members to our competitors that could offer the breadth of insurance capabilities."

Only one issuer noted the advantages of integrated networks for providers. This issuer commented that its providers saw advantages to participating across product lines as a way to maintain consistent relationships with their patients. “Our providers also wanted more stable panels because every time one of our members would lose eligibility, the provider would lose them from their panel.” Further, the process of losing a patient can be administratively burdensome for providers; maintaining their coverage can reduce unwanted paperwork and correspondence.

Issuers offering both Marketplace and Medicaid/CHIP coverage approach contracting with providers in two different ways—“all products” and “selective contracting”; the first approach lends itself to greater network overlap. In general, the four issuers offering both types of products reported two different approaches to contracting with providers. Two issuers reported taking an “all-products” approach to provider contracting, meaning that they asked and encouraged providers to participate across all lines of business—Marketplace, Medicaid/CHIP, and commercial (if offered). As one issuer put it, “In our contracting efforts, our approach is to offer our spectrum of services or lines of business that we serve within the community. We always speak to the provider . . . from an organizational perspective so that they could serve us enterprise wide.” Of those taking this approach, the issuer with the most integrated network found that it kept the contracts, reimbursement rates and schedules, and other paperwork materials for providers common across products. Also, maintaining the same reimbursement schedules across products helped boost the percentage of providers who were willing to participate in all programs and see enrollees across the spectrum of products. The issuer said that providers knew about the service offered by this particular issuer, which helped facilitate participation across all products. “Anecdotally, we hear that the providers prefer to work with us because we are reasonable when it comes to all of the different criteria like requests for review, authorization, determinations, etc. They find that some of the other [issuers] are a little bit stricter or require a higher level of documentation and several levels of continued review. I think they find it relatively easy to work with us.”

The other issuer taking this approach, but whose networks were not as highly integrated, noted that although it encouraged providers to participate across all lines of business, not all providers were willing to do so. When a provider refused to participate in a particular network, the issuer tried to understand the reason and see if it could do anything to ameliorate the issue, such as to consider higher reimbursement, provide education, or engage them in friendly competition with other providers in the area. As this issuer stated, “We don’t offer much encouragement except to get to the heart of why they don’t want to participate—if it’s a rate issue, we look at proposals from them and see if we can make it work actuarially with a higher rate. If it’s an education issue, we will go out and do on-site visits that showcase and provide materials on all products, including [the Marketplace] . . . We also let them know in some instances that their colleague down the street is participating . . . to let them know if they don’t participate, they’re missing out.”

Issuers that selectively contract with providers as a way to lower costs noted that this decision may have had negative network overlap implications. Two issuers that did not take an all-products approach said the differences in contracting across product lines were due to disparities in the needs of the different populations covered. These issuers said they built their networks based on population needs rather than overlap. For example, one noted that its

Marketplace and Medicaid/CHIP networks were quite similar; the main differences was that the Marketplace network did not include the county health system because it was not as critical to the needs of that particular population. The Medicaid/CHIP network concentrated on the safety net, whereas the Marketplace network did not require as much reliance on ECPs.

The other issuer commented that its networks are built based on consumer demand: if a gap exists in a network, they will fill it, but that does not mean all networks will face the same gaps at the same time; thus, networks will develop different sets of providers organically. These two issuers recognized that the decision to selectively contract meant they experienced a lower degree of provider overlap across networks.

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V. MEMBER OUTREACH AND ENROLLMENT

Key Findings:

- Regulations for marketing and outreach to consumers differ across states and program types. Despite these variations, the strategies issuers reported employing are quite similar, and include mass media campaigns, participation in community events and health fairs, and partnering with community providers to raise awareness. Marketing was especially important for CO-OP issuers, due to their status as newly created entities.
- The assistance available to consumers at the point of enrollment appears comparable across programs and locations; it includes Navigators, certified application counselors (CACs), and member services help lines; these services were especially crucial, given the enrollment challenges faced during the first open enrollment period.
- All of the issuers interviewed offer potential members access to provider network directories to help consumers make informed choices when selecting plans, although some noted that consumers need still more information to understand their choices.

Outreach and enrollment strategies can lead to more efficient, informed, and satisfying enrollment experiences for potential enrollees. Outreach and marketing can help educate individuals who are trying to understand their options when first enrolling in the Marketplaces and can help issuers that are offering similar products differentiate themselves to consumers. Furthermore, enrollment assistance offers help to those trying to navigate both the federal and state Marketplace websites, and may aid them in overcoming barriers encountered during the various enrollment processes used by Medicaid/CHIP entities. In Section A of this chapter, we discuss marketing and other outreach regulations, and how they have shaped issuer efforts. In Section B, we discuss enrollment assistance provided by issuers, how issuers differentiate themselves to consumers in the strictly regulated Marketplace plan environment, and how potential enrollees come to make informed choices and perceive their experiences with enrollment.

A. Marketing regulation and issuer responses

1. Marketing and outreach regulation

Regulations regarding marketing and outreach activities for the Marketplace are largely defined at the state level. In fact, for QHPs in federally facilitated and federal-state state partnership Marketplaces, federal regulations require issuers to comply with state-specific laws regarding health plan marketing and specify that marketing practices should not discourage enrollment of individuals with significant health care needs (45 CFR 156.225). CMS released guidance for QHP marketing, which also states that issuers must ensure that marketing materials are accessible to individuals with limited English proficiency and those with disabilities. The guidance also states that CMS generally will not review any marketing for compliance with state regulations (CCIIO 2013).

All six states included in this study have rules regarding fair and accurate marketing practices for Marketplace issuers: advertisements must be readable, not misleading, and cannot entice potential enrollees with promotional offers or incentives. The states also specify that issuers cannot conduct any direct marketing but allows them to conduct mass media and other broad-level marketing campaigns as long as they do so throughout the entire areas they serve in the state. Issuers also must either submit their Marketplace marketing materials to state agencies or make them available upon request, though prior approval by the agency generally is not required (AAC R20-6-201; Covered California 2013; Illinois Department of Insurance 2013; 806 KAR 12:010; 900 KAR 10:010E; Maryland Health Benefit Exchange 2013; New York State of Health 2013).

The federal government regulates Medicaid/CHIP issuers' ability to market, and most states included in our study have additional restrictions. Federal regulations established general rules for all state Medicaid managed care plans to follow. These regulations are similar to those described earlier established by states for their Marketplace QHPs: fair and accurate marketing practices, no direct marketing, and requiring campaigns to be conducted in the entire area in which issuers serve. Federal regulations also specify that any Medicaid marketing materials must be approved by the state prior to distribution (42 CFR 438.104). Similarly, CHIP issuers may conduct advertising campaigns as long as they are included in their respective approved state plan (42 CFR 457.90).

Five of the six states included in this study (all but Maryland) have implemented additional restrictions on issuer marketing activities. Arizona and New York, for example, both explicitly state that issuers cannot refer to their competitors in their marketing materials. Illinois and New York require that all marketing personnel be trained and credentialed. Most states place restrictions or specify only certain areas where information can be disseminated: for example, issuers in Arizona are allowed to conduct marketing only at health-related events and not through any mass media; Kentucky, on the other hand, does not allow any face-to-face marketing, but rather only mass media campaigns (Arizona Health Care Cost Containment System 2012; California Department of Health Care Services 2013; 22 CCR 53880; Illinois Department of Healthcare and Family Services 2014; 907 KAR 17:010; COMAR 10.09.65.23; New York State Department of Health 2011).

2. Issuer perceptions and implementation

Although regulations differ across programs and states, issuers report that their marketing and outreach strategies are similar, regardless of the program(s) or state(s) in which they participate. Most of the issuers that provided a summary of outreach and marketing activities to us reported the use of mass media as part of their overall campaigns, including billboards, television and radio advertisements, and print and online advertisements. Several also participate in community events and health fairs, where they can provide more targeted outreach to populations of interest.

Some issuers, particularly the four non-CO-OPs participating in the Marketplace only, are forming marketing relationships with entities serving individuals that may not necessarily qualify at the time but may become eligible for Marketplace coverage in the future. For example, those issuers are actively involved in outreach through partnerships with community providers, aiming to raise awareness and education for individuals typically enrolled in Medicaid/CHIP or those

who are uninsured. Marketplace-only issuers also have established marketing partnerships with other plans, typically administered by issuers offering only Medicaid/CHIP.

In addition to advertising to increase their own enrollment, some issuers offering Marketplace plans also conducted more general marketing campaigns about the Marketplace in their state as a whole to raise awareness of both the Marketplace and the benefits of being covered. The CO-OP issuers in particular formed their marketing strategies in part to simply advertise their creation. These issuers mentioned that their efforts “. . . tried to make folks aware of our existence,” because “no one has ever heard of us before.”

One Marketplace issuer is working with a Medicaid plan “. . .to do a bit of an outreach effort for those people who are coming off [Medicaid] and saying to them, ‘If you work with [us], it’s the same providers [in our network as theirs].’”

B. Enrollment assistance and experiences

Marketplace issuers were required to interface with newly created state and federal Marketplace enrollment systems, leading to well-documented successes and failures for enrolling individuals during the start of the open enrollment period. In addition, recent changes in Medicaid/CHIP enrollment processes have been implemented as a result of the Affordable Care Act, such as the creation of online, real-time enrollment systems (Hoag et al. 2013). As such, issuers can provide various forms of assistance to help their potential enrollees overcome obstacles faced during the enrollment process. Furthermore, gleaned information from recent member enrollment experiences can help shape strategies to better serve future enrollees.

Of the nine issuers responding, most offer similar types of enrollment assistance to their enrollees, regardless of program. Several issuers provide customer assistance using call centers or web-based support while an individual is online and attempting to enroll. Though they specifically employed most of the dedicated staff members to assist with enrollment in their plans, two issuers mentioned that their staff include certified application counselors (CACs) and that they help individuals enroll regardless of program eligibility or of the plan in which they ultimately decide to enroll. According to one issuer, “We make ourselves available for any questions about the process . . . ultimately who they end up choosing is their decision.” Only two responding issuers (both offering Medicaid/CHIP only) stated that they provide no enrollment assistance: for one issuer, all enrollment to their plan goes through a broker, whereas the other reported being prohibited by state regulations from offering enrollment assistance.

Other entities have been certified to assist individuals during the enrollment process. In addition to the CACs, certified Navigators¹⁹ also offer unbiased assistance at the point of enrollment. These assistors underwent state-specific training to help individuals navigate eligibility determinations, federal subsidies, the enrollment process, provider network searches, benefit designs, and other potential issues of concern for consumers, particularly those who may be purchasing health insurance for the first time. Several of the states included in our study have either passed or have pending legislation to further license and regulate assistors (NCSL 2014).

¹⁹ Although issuers are allowed to staff or otherwise have relationships with CACs if the counselors disclose their relationship with the issuer to individuals they assist, the Affordable Care Act specifically prohibits issuers from becoming Navigators (P.L. 111-148).

All issuers offer potential enrollees provider network directories to help them make informed choices when selecting plans, although some noted that consumers still need more information to understand their choices. All issuers we interviewed make provider directories available to the public prior to enrollment so that an individual can determine whether a particular provider participates in a given plan; these usually are accessible on the Internet, but some issuers also provide information through hard copy directories or a call center. These responses are consistent with what we found in our earlier study, as we were able to retrieve directories for all but one of the issuers identified in the six market areas.

One Marketplace issuer reported that, “There needed to be more opportunities to educate people about product offerings and what they mean. There was confusion around the metallic levels.”

Though issuers did provide information about providers and their product offerings, two noted that consumers could use more information when making enrollment decisions. One issuer commented that individuals were not as aware of the structure of the various offerings in the Marketplace, and another noted that “. . . continued outreach to members is very important so that they are clear as to the benefits they have purchased.”

Issuers reported that enrollees faced numerous challenges during enrollment on the federal and some state Marketplace websites. Though Marketplace enrollment ultimately was larger than expected due to a surge in March 2014 (Office of the Assistant Secretary for Planning and Evaluation 2014), not surprisingly, multiple issuers mentioned problems with their respective Marketplace websites, especially during the first several weeks of the open enrollment period. Issues included long delays in processing responses during the application process and inaccuracies with the provider directories available on the website. Issuers also commented that the relatively cumbersome process of navigating the websites in general could lead to the loss of potential enrollees. For example, one issuer said that “The [Marketplace] website is not very nimble . . . the more hoops people have to jump through, more people fall through the cracks.”

Because most Marketplace plans are required to be largely similar in terms of cost-sharing and benefits, issuers have developed a variety of strategies to differentiate themselves from their competitors and to encourage enrollment in their plans. Several issuers cited the ability to offer “value” rather than solely competing on price, combining affordability with offering a broader network and a larger number of products. Some issuers were also able to successfully leverage brand recognition to attract enrollees. Another issuer is experimenting with using technology to create convenience for enrollees: “[Enrollees] can use tech to interact rather than traditional office visits. We are trying to create a new way in which members can access their benefits.”

Marketplace CO-OP issuers also identified value as being a large driver in attracting consumers to enroll, as they typically could not compete on price alone. One issuer commented that, “We are more inclined to have a lower, more manageable deductible, where people aren’t afraid to utilize the care. They can seek the care that they need and get better, as opposed to not seeking care because it is cost prohibitive.” Multiple CO-OPs also identified that enrollees are able to hold the issuer to a level of accountability, giving enrollees “a voice” in the management of their plans.

VI. NETWORK ADEQUACY STANDARDS AND MONITORING NETWORK COMPLIANCE

Key Findings:

- The federal government sets Marketplace network adequacy standards, although states have a great deal of flexibility in interpreting the regulations. Issuers must also comply with any state standards that were in place prior to the Affordable Care Act. Issuers perceived the standards to be fairly similar across programs, although some perceived the Medicaid/CHIP network adequacy standards as more straightforward.
- In general, existing Marketplace issuers viewed the standards as relatively lenient; several reported needing to recruit essential community providers (ECPs) to their networks, but otherwise did not struggle to comply. CO-OP issuers reported more challenges, potentially due to the practice of leasing outside networks as well as their status as new issuers.
- Issuers across products use similar processes for internally monitoring network adequacy, including Geoaccess software and in-house tools to monitor enrollee-to-provider ratios. Whereas Medicaid/CHIP issuers were clear about how the state monitored their network adequacy, one Marketplace issuer expressed a lack of understanding about how the state monitored Marketplace network adequacy.
- All Marketplace issuers provide online provider network directories, which are updated frequently—if not daily. Nearly all Medicaid/CHIP issuers in the study also provide online provider network directories.

Network adequacy standards are meant to ensure that a health plan has the ability to provide enrollees with timely access to a sufficient number of in-network providers under the terms of a contract. States have taken different approaches to regulating network adequacy as they try to balance access to care with the goals of controlling costs and attracting issuers into the market. In this section, we review network adequacy standards for issuers participating in the Marketplace and Medicaid/CHIP, issuers' perceptions about those requirements, and consumers' access to the provider network directories.

A. Background: network adequacy standards

The Affordable Care Act established new federal network adequacy standards for QHPs, which require plans to maintain a provider network that is “sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.” As implemented, states and issuers have considerable flexibility in interpreting what constitutes “sufficient and reasonable” and “unreasonable delay.” QHPs must also comply with any state standards that were in place prior to the Affordable Care Act (Bauman et al. 2014), as well as any additional standards set by states conducting plan management for the Marketplace, either as a state-based or a federal-state partnership Marketplace. Three of the six states in this study (California, Illinois, and New York) have adopted network adequacy standards that go beyond the federal requirements (Table VI.1) (Rosenbaum et al. 2013).

Table VI.1. Network adequacy standards

The Affordable Care Act requires the Secretary of HHS to establish criteria for the certification of health plans as QHPs to be offered in a state's health insurance Marketplaces. These criteria include requirements to do the following:

- Ensure a sufficient choice of providers
- Provide information to enrollees and prospective enrollees on the availability of both in-network and out-of-network providers
- Include within plan networks, where available, essential community providers that serve predominately low-income, medically underserved individuals

Final rules published by HHS in 2012 elaborate on the minimum network adequacy requirements that a QHP must meet. A QHP issuer must maintain a provider network that meets the following standards:

- Includes essential community providers in accordance with 45 CFR 156.235
- Is sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to ensure that all services will be accessible without unreasonable delay
- Is consistent with the network adequacy provisions of section 2702(c) of the Public Health Service Act^a

Sources: P.L. 111-148, Section 1311; 45 CFR 156.230; 42 CFR 300gg-1.

^a The Public Health Service Act (Section 2702) requires that health insurance be offered on a guaranteed issue basis. 2702(c) provides two exceptions to this requirement applicable to plans utilizing a network: (1) plans may limit coverage to eligible enrollees who live or work in the service area, and (2) an issuer may refuse to enroll new eligible employers or new eligible individuals if the issuer does not have the capacity to meet the needs of existing enrollees and issue coverage to new enrollees.

The Affordable Care Act also requires issuers to have a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the plan's service area. The statute refers to providers participating in the 340B drug pricing program²⁰ and those eligible for Section 1927 "nominal drug pricing"²¹ as examples of ECPs. Federally facilitated Marketplaces are required to verify that at least 10 percent of ECP participation is in network and in the service area, and must submit a satisfactory narrative justification as part of the Issuer Application. If issuers fail to achieve this standard, however, they can submit a satisfactory narrative justification for consideration. States conducting plan management for the Marketplace, either as a state-based or federal-state partnership Marketplace, have flexibility in establishing their own limits. California was the only state in our study to establish a different ECP criterion, requiring QHP issuers to contract with at least 15 percent of ECPs listed as 340B nonhospital and hospital entities (McCarty and Farris 2013).

State-based Marketplaces and federal-state partnership Marketplaces are responsible for reviewing provider network adequacy (California, Maryland, New York, Kentucky, and Illinois), though each state has taken its own approach. For example, in California, issuers had to submit

²⁰ The 340B drug pricing program requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices. Eligible organizations include Federally Qualified Health Centers, Ryan White HIV/AIDS Program Grantees, and certain types of hospitals and specialized clinics (Health Resources and Services Administration 2014).

²¹ Section 1927 of the Social Security Act allows the Secretary of the U.S. Department of Health and Human Services to determine additional safety net providers to which sales of drugs at a nominal price would be appropriate.

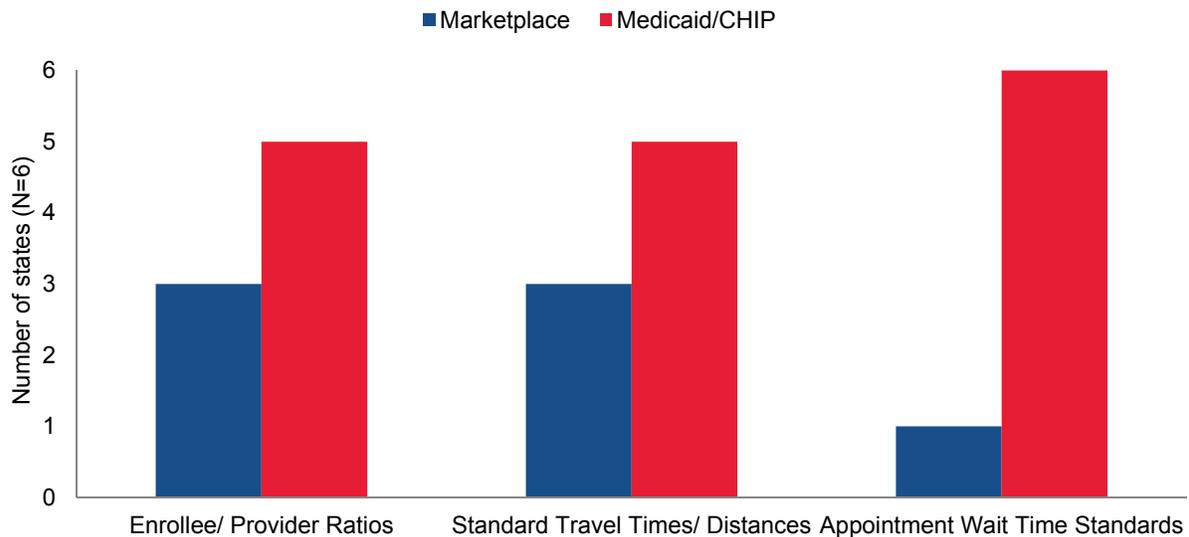
provider contracts to the California Health Benefit Exchange (McCarty and Farris 2013),²² whereas in Maryland, the Maryland Health Benefit Exchange allowed carriers to “self-define” network adequacy standards in 2014. CMS allowed federally facilitated Marketplace states, such as Arizona, to conduct network adequacy reviews in 2014 if the state already had the authority and means to assess issuer network adequacy and standards at least as stringent as those identified in 45 CFR 156.230(a). Arizona had an established review for HMO but not PPO plans, so CMS accepted issuers’ accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity. Unaccredited issuers had to submit an access plan as part of their QHP applications.

Managed care plans in Medicaid and CHIP are subject to the same federal network adequacy requirements, which states can define more stringently in their contracts with issuers. States must establish “standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity (1932(c)(1)(A)(i)).” Each Medicaid/CHIP issuer must demonstrate that it has “the capacity to serve the expected enrollment” in its service area and also must offer “an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled,” and maintain “a sufficient number, mix, and geographic distribution of providers and services.” Building on federal Medicaid rules, state contracts with issuers detail standards for access and availability to reflect the geographic and demographic diversity of the states.

Because the federal government allows states to interpret and set more stringent requirements, states have taken different approaches to establishing network adequacy standards for the Marketplace and Medicaid/CHIP. Some have set quantitative standards, such as time and distance limits, provider-to-enrollee ratios, and appointment waiting time limits. As shown in Figure VI.1, the six states in this study had more clearly defined, quantitative network adequacy standards for Medicaid/CHIP than Marketplace issuers.

²² In addition, plans had to attest that they met California’s Department of Managed Health Care (DMHC) standards. DMHC is responsible for regulating the adequacy of HMO networks, whereas the California Department of Insurance (CDI) is responsible for other issuers that utilize provider networks requirements.

Figure VI.1. Number of states with specific network adequacy requirements, by program type



Source: Summary of Appendix B, which provides detailed information about the specific network adequacy requirements by state.

B. Issuer perceptions

Issuers that offered plans in multiple programs reported that the network adequacy standards are similar between the Marketplace and Medicaid/CHIP, though Medicaid/CHIP has more clearly defined standards. Two out of the three issuers responding reported that network adequacy requirements are similar between the Marketplace and Medicaid; the third issuer reported that Medicaid has more stringent requirements, such as clearly defined time and distance requirements.

Established issuers, whether previously operating in Medicaid/CHIP or the commercial market, reported that network adequacy standards in the Marketplace are fairly lenient, whereas some CO-OPs reported challenges complying. Issuers are aware of the specific network adequacy requirements in their states, though four out of seven responding described them as not very robust or stringent. Two issuers reported that they go beyond the Marketplace’s network adequacy standards; for example, one issuer required its Marketplace networks to align with CMS Medicare Advantage network adequacy standards, which have more robust requirements. CO-OPs reported more problems in developing sufficient provider networks. For example, one CO-OP struggled because the network it was leasing was adequate in most counties but initially failed to meet the standards statewide.

One issuer reported that “The QHP has a network adequacy standard, but it’s extraordinarily thin. If we have a hospital on the north side, one on the south side, and a few providers, we can meet the network adequacy standards set down by the federal government.”

The main concern Marketplace issuers raised regarding compliance was with the ECP requirement. Existing commercial issuers and CO-OPs that did not have ECPs in their own proprietary or leased networks reported some challenges in contracting with these providers. One issuer reported that “A lot of the recruitment that we did was with federally qualified health centers. They were concerned about access because they have high volumes coming through the door already, so they were worried about bringing these additional patients in. But they realized that it wasn’t all new patients because many would be patients that they had been seeing on a cash basis that were now covered, so they realized that access wasn’t quite as much of an issue.” Issuers offering products through both programs did not report problems including ECPs in their Marketplace networks, since these providers, issuers said, are already in their Medicaid/CHIP networks and were able to be recruited to crossover to the Marketplace networks.

One Medicaid/CHIP issuer said “The state uses the standards that are in their contract with us and sends us a monthly report noting areas that do not meet the adequacy minimums. The report is based on the provider network directory that we send the state. The state doesn’t assess most areas very closely; however, there are some exceptions related to recent network expansion, including the new substance abuse benefit and psychiatric network that the state is particularly interested in right now.”

Issuers across products use similar processes for monitoring network adequacy; however, at least one issuer expressed uncertainty about the state review process for Marketplace plans.

All existing Marketplace issuers and all but one Medicaid/CHIP-only issuers reported using Geoaccess software to ensure that they are meeting time and distance network adequacy requirements. One Medicaid/CHIP issuer used several tools, including flex analytics and an in-house tool that monitors member-to-provider ratios based on open and closed panels. Among issuers offering multiple products, all three responding reported that they have tried to standardize their internal monitoring process for Marketplace and Medicaid/CHIP programs. Although the Medicaid/CHIP issuers were clear about how the state monitored their network adequacy, one issuer offering coverage through both programs expressed a lack of understanding about how the state was using the Marketplace data submitted to monitor network adequacy.

C. Provider directory regulations and consumer grievance process

The Affordable Care Act requires Marketplace issuers to make provider network directories available for publication online and in hard copy to potential enrollees upon request. As discussed in Chapter V.B, all Marketplace issuers had online searchable provider network directories, and most provide consumers with hard copy directories when requested. In the directory, issuers must identify providers not currently accepting new patients (45 CFR 156.230(b)). The final rule does not include guidelines on how often the directories must be updated; rather, it suggests that each Marketplace consider balancing consumer choice with the issuer’s regulatory burden to comply (McCarty and Farris 2013). Marketplace and Medicaid/CHIP issuers reported that they update their provider network directories frequently; seven out of nine issuers responding reported updating them weekly, if not daily.

Although the federal Marketplace website did not attempt to publish provider network directories in 2014 (referring potential enrollees to each individual issuer’s website instead), several state-based Marketplaces attempted to publish them directly, with

challenges. Issuers agree that there were inaccuracies in Marketplace provider directories in 2014, especially those posted on state-based Marketplace websites. Three issuers acknowledged that there have been accuracy issues with their provider network directories in the Marketplace. One issuer noted, “I think that the provider directories were an issue and remain an issue for all of the plans. [Our state’s Marketplace] pulled down their directory because of the inaccuracies. Those inaccuracies were probably caused by both the plan submission and how [the state Marketplace] organized the data.”

Issuers track member grievances about specific providers not being in network and often attempt either to recruit those providers or preapprove visits. Federal regulations require issuers in federal and federal-state partnership Marketplaces to investigate and resolve member grievances received through either an issuer’s internal customer service department or a CMS-developed grievance tracker. The regulations also outline time frames for resolution and require issuers to adhere to state standards if they are stricter than those outlined (CCIIO 2014b). In addition to issuer-specific and federal-level complaint systems, all of our study states also make grievance forms available through their respective insurance departments. Several issuers reported that, to help in processing member grievances, including those about provider access, they use internal trackers to monitor the progress of resolving grievances. Two of these issuers also said they are required by state law to have member grievance departments.

Issuers reported a number of strategies to help resolve member complaints about accessing providers not in their networks. Four out of seven issuers said they attempt to contact the provider in question for recruitment into their networks. In addition, one issuer noted that they attempt to redirect their customers to a physician participating in their network. Other strategies issuers reported were to contract with the provider on a case-by-case basis or require preapproval for the physician to receive reimbursement.

VII. TRANSITIONS AND CONTINUITY OF CARE

Key Findings:

- Defining program eligibility based on income neatly divides individuals between the Marketplace and Medicaid/CHIP at any single point in time, but family income and composition evolves, resulting in potential eligibility changes that require individuals to transition across programs.
- Policy mechanisms have been enacted to help ease transitions, including continuity-of-care laws and bridge plan legislation. Continuity-of-care laws are important policy mechanisms that help ensure smooth transitions for individuals with serious medical needs; issuers reported that they were in compliance with these laws. California is the only state in our study currently considering bridge plan legislation, and issuers were uncertain about this approach.
- Issuers were aware of potential problems with transitions across programs and, although they could speak only hypothetically about them, they expressed concerns about both the negative consequences for enrollees, providers, and their own firms. To ease transitions for enrollees, some issuers are taking steps to encourage them to stay with the same issuer when transitioning or otherwise make informed decisions that would enable them to maximize continuity of care.
- By virtue of the way the programs are designed and administered, issuers—even those participating in multiple programs—currently treat the programs relatively distinctly.

Frequent transitions between the Marketplace and Medicaid/CHIP health coverage are likely to occur and cause problems for health insurance issuers, providers, and the individuals and families undergoing the transition. In this section, we examine transitions and the policy mechanisms in place to ease those processes (Section A), and the decisions issuers have made regarding transitions in response to the Affordable Care Act (Section B).

A. Background: the transition process

The Affordable Care Act significantly increases health care coverage options for low- and middle-income individuals through two main pathways. The first allows states to expand Medicaid coverage for people with annual incomes of up to 138 percent of the federal poverty level.²³ The second pathway subsidizes private coverage purchased through the Marketplaces for people with incomes of 138–400 percent of poverty who do not have an offer of affordable coverage through an employer and are not eligible for other public coverage.²⁴ The Affordable Care Act leaves in place previous Medicaid/CHIP eligibility thresholds for children, which often are greater than 138 percent of the federal poverty level, meaning that, in a single family, parents

²³ The law allows states to expand Medicaid eligibility for people with incomes up to 133 percent below the federal poverty level, with a 5 percent disregard (P.L. 111-148, Section 2001).

²⁴ People with incomes between 100 and 138 percent of the poverty line who are determined to be eligible for Medicaid are not eligible for premium tax credits, so we assume they will transfer into Medicaid.

may be eligible to purchase coverage through the Marketplace, while children are covered by Medicaid or CHIP.²⁵

This income-sensitive approach to subsidizing the cost of health insurance neatly divides individuals between the Marketplace, Medicaid and CHIP eligibility at any point in time. Income fluctuates, however, and family compositions (such as marriage or the birth of a child) change over time and affect income-related eligibility. It is too early to know exactly how many people will be affected by eligibility changes that necessitate transitioning across programs, but a recent study estimated that nearly one-third of all adults with family incomes below 400 percent of the federal poverty level would experience a shift in eligibility within six months, and half would change their eligibility status within a year (Sommers et al. 2014).

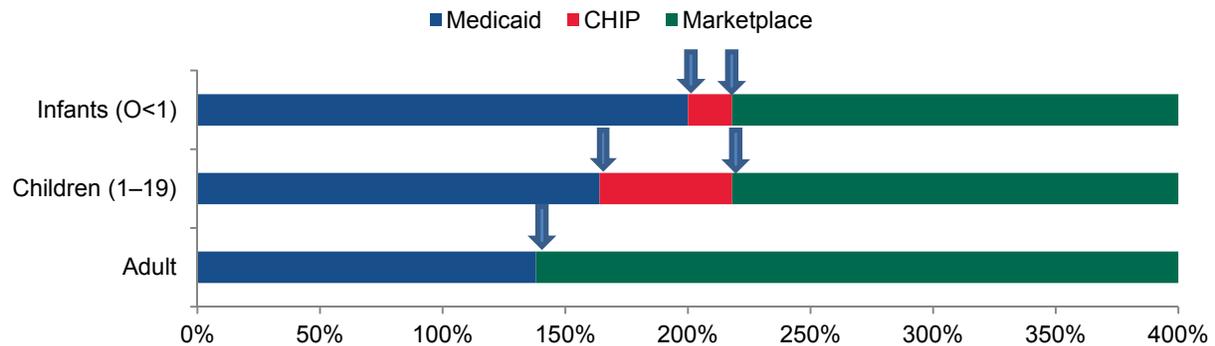
For adults, the Marketplace and Medicaid programs typically require individuals to report changes in their income or family composition, which may trigger a review of their eligibility for health coverage. For example, if an individual enrolled through the Marketplace experiences a decrease in income below the Medicaid eligibility level, he/she will be required to terminate Marketplace coverage and enroll in Medicaid.²⁶ Similarly, if an individual's income rises above the Medicaid threshold, he/she may lose public coverage but qualify to enroll through the Marketplace (and be able to enroll outside of open enrollment because losing public coverage is considered a special qualifying event). In states expanding Medicaid eligibility, adults will transition between Marketplace and Medicaid eligibility when they report income fluctuations above and below 138 percent of the federal poverty level.

Transition points for children are more variable than for adults. States have different eligibility thresholds for Medicaid and CHIP, which often vary by age. For example, as shown in Figure VII.1, infants in Kentucky are eligible for Medicaid if their family income is less than 200 percent of the federal poverty level, but the Medicaid-eligible threshold for children (ages 1–19) drops to 164 percent. Both infants and children remain eligible for public coverage under CHIP until their family income goes to 218 percent of the federal poverty level; their eligibility then shifts to the Marketplace. The six states in this study each have different eligibility thresholds for Medicaid and CHIP, so unlike the adult population, children have no uniform transition point.

²⁵ The Affordable Care Act includes a “maintenance of effort” requirement that states keep the same eligibility thresholds for children in Medicaid and CHIP until October 1, 2019.

²⁶ This example assumes that the individual lives in a state that expanded Medicaid. If the individual lives in a state that did not expand Medicaid, he or she could lose coverage entirely if his/her income falls below 100 percent of the federal poverty line but is still too high to qualify for Medicaid in the state.

Figure VII.1. Marketplace, Medicaid, and CHIP eligibility transition thresholds in Kentucky



Source: CMS 2014b.

Note: Arrows denote when shifts in eligibility are likely to occur for adults, children, and infants in Kentucky. CHIP = Children's Health Insurance Program.

Transitions for children also are more difficult to determine than for adults, due to continuous coverage laws, which allow fluctuations in income to go unreported for specified periods of time. Four of the six study states (all but Kentucky and Maryland) have continuous coverage laws that allow children to maintain Medicaid and CHIP coverage for 12 months (CMS 2014a).²⁷ Thus, a child may remain under public coverage for up to a year even if the family experiences a change in income that otherwise would make him/her ineligible. These laws help children retain more consistent coverage than adults but also add another facet in determining when a shift in eligibility will occur for children.

Continuity-of-care laws or administrative rules are important policy mechanisms that have been enacted by many state legislatures and regulators over the past decade to help ensure smooth transitions for individuals having serious medical needs; issuers reported that they are in compliance with these laws.²⁸ All six states in this study have continuity-of-care rules that aim to avoid disruptions in care when the physician can no longer see a patient because of a change in health plan or because a provider ceases participation in a provider network. (Appendix Table A.3 provides more detail on the continuity of care rules enacted in the six states in this study). For enrollees undergoing treatment by a provider at the time of the provider's network termination, such rules tend to require plans to continue coverage for treatment by that provider for (1) pregnancy, (2) acute illness,

A Marketplace issuer commented, "The state has very specific requirements around continuity and has had them for the last 10 years. So when the [Marketplace] started, we already had rules in place. The state has [its] own set of continuity-of-care regulations that we follow. We also have our own continuity-of-care requirements that go beyond what the state requires. We ensure that transition assistance is made available to members who qualify, depending on the situation."

²⁷ Arizona's law only guarantees continuous coverage during the first year of coverage in Medicaid.

²⁸ Five out of the six study states have enacted continuity-of-care laws, while California has added these rules as an amendment to Section 1373.96 of the Health and Safety Code.

or (3) chronic illness (e.g., those that are life threatening, degenerative, or disabling). These laws typically require that plans extend in-network coverage for 60 or 90 days—in the case of pregnancy, through the completion of postpartum care, and, for terminal illness, for the remainder of the individual's life. Marketplace issuers reported that continuity-of-care rules are well defined and that they are in compliance with these state laws. Three out of eight Marketplace issuers reported that they have additional internal continuity-of-care standards to ensure enrollees with serious medical conditions receive the care they need.

Federal regulations allow Medicaid/CHIP issuers to offer bridge plans in state-based Marketplaces on a limited enrollment basis to address continuity-of-care issues at the point of transition. Bridge plans are Marketplace QHPs that Medicaid/CHIP issuers offer specifically for those making transitions from Medicaid/CHIP to subsidized Marketplace coverage (CMS 2012). Bridge plans aim to improve continuity between provider networks and allow for the possibility that families can be covered under one umbrella plan when they otherwise might have some family members qualifying for Medicaid/CHIP and others qualifying for Marketplace coverage (CMS 2012). Bridge plans are only for people who had Medicaid/CHIP and are not available to others purchasing insurance in the Marketplace. California was the only state in our study to pass legislation to allow for bridge plans on its state-based Marketplace, but complications surrounding subsidy calculations have delayed implementation (California Legislative Information 2013). Three of the California issuers that we interviewed expressed concerns about the feasibility of the bridge plan model, such as their ability to price the product affordably, given that enrollees must have access to the full Medicaid/CHIP network, and potential confusion with provider reimbursement schedules.

B. Issuer concerns about transitions

Issuers voiced concerns that the transition process is not well coordinated and could result in disruptions in continuity of care for enrollees, higher administrative costs for providers, and a less stable risk pool for their firms.²⁹ Three out of four issuers who offered both Marketplace and Medicaid/CHIP coverage specifically mentioned that there is no systematic or automatic way of transitioning individuals between programs, resulting in manual

As one issuer with high-integration networks reported, “We have a focus on provider and member disruption and we want to minimize that to the greatest degree possible because not only does it affect the member, but it affects the provider too. They have to transfer medical records and coordinate with other providers, and that adds a level of complexity that doesn’t need to be there.”

(as opposed to automatic) processes and potential confusion on behalf of enrollees and issuers alike. Further, the current process places the transition burden on the individual. For example, in the case of transitioning from Medicaid to the Marketplace, an individual has a special enrollment opportunity that lasts 60 days from experiencing a qualifying event (i.e., losing Medicaid coverage) to enroll in Marketplace coverage. If an individual fails to enroll during this window, he/she will not be able to enroll in a Marketplace QHP until the next open enrollment period.

²⁹ Although the association is difficult to measure, research suggests a positive relationship between continuity of care and health care outcomes (van Walraven et al. 2010; Gill and Mainous 1998; Christakis et al. 2001).

Issuers that offer coverage through both programs reported trying to ease the transition between the Marketplace and Medicaid/CHIP by offering transition assistance when an individual disenrolls from one of their health plans. The four issuers that offered multiple products all said they reach out to consumers (or intend to reach out to consumers, as some issuers had not yet experienced any disenrollments) to provide them with information about the other products they offer at the point of transition, either when they disenroll from a plan or simply stop paying their premiums. This outreach is aimed to benefit their bottom line, as it may help them retain enrollees, but it may also have positive continuity of care implications. These types of outreach include sending materials that would help alert consumers to other coverage options and offering ideas about what plans or issuers might offer them the best prospects for continuity of care. Outside of these efforts, other types of consumer assistance are available at the point of transition that mirror the types of consumer assistance available at the point of enrollment (as discussed in Chapter V.B), including Navigators and CACs that offer unbiased assistance and are trained to help consumers consider continuity of care when switching plans.

Issuers that offer multiple product lines considered the transition problem when they designed their networks, and all reported trying to align their Marketplace and Medicaid/CHIP networks to reduce continuity of care problems. One Medicaid/CHIP issuer participating in the Marketplace said, “That’s the whole idea behind the parallel construct with the network. The Medicaid part of our network is much better established. The people we are going after to build the exchange network are the exact same providers. So keeping the [primary care physicians] the same is our exact intention. Not only is this about having a product for the individual member, but with the exchange, we now have products for the whole family. It used to be possible for three very different plans to be taking care of the same family so now we can more holistically cover the family.” As described in Chapter IV.B, one CO-OP is addressing this issue by forming a partnership with a Medicaid/CHIP issuer in its market area and streamlining the networks, benefits, and plan designs across programs. At the point of transition from either issuer, consumers will receive information about the benefits of enrolling in coverage with the partner issuer, which include the option of seamless coverage with their current provider.

One major limitation is that, by virtue of the way the programs are designed and administered, issuers (even those participating in multiple programs) currently treat the programs relatively distinctly. Whereas the same department in a state often administers Medicaid and CHIP (generally different units within the same department), a separate government agency tends to conduct regulation of the Marketplace and other commercial insurance products. For example, in New York, the Department of Financial Services oversees commercial insurance, whereas Medicaid and CHIP have their own unique divisions within the Department of Health. Of the six states in our study, five have separate administration of Marketplace and Medicaid/CHIP programs (New York established the New York Health Benefit Exchange within the Department of Health, which also oversees Medicaid/CHIP). Issuers cited separate administration of the programs as both a challenge and a reason for some of the anticipated technical issues encountered at the point of transition. “I think the largest impact for us isn’t in the community or the purchasers, but more so on the technical end. There are different agencies in the state that oversee the commercial versus the Medicaid versus the CHIP. And while they come together in some aspects, it’s not enough for there to be fluidity between the levels of coverage that someone can enroll in.”

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 VIII. LESSONS LEARNED AND ANTICIPATED CHANGES

Key Findings:

- Marketplace issuers gained insight into consumer behavior and decision-making processes during the first open enrollment period, but some drew different conclusions about the importance of price and provider choice. All of them entered the first open enrollment period thinking that “price was king”—some issuers found this assumption validated, whereas others were surprised at the number of consumers who appeared to make their selection based on brand, quality, or other factors.
- Despite the multipronged outreach strategies in anticipation of and during the first open enrollment period, issuers reported that gaps in consumer and provider education remain.
- None of the issuers interviewed reported plans to leave the Marketplace or Medicaid/CHIP in future years. In fact, five of the eight Marketplace-only and four of the six Medicaid/CHIP-only issuers reported considering entering the corresponding program at some time in the future, although not in the upcoming year.
- For the 2015 plan year, Marketplace issuers reported making changes to product design and premiums in response to lessons learned during the first open enrollment.

The timing of our interviews with health insurance issuers was fortuitous. Conducting interviews in May–July 2014 meant that issuers were removed enough from the first open enrollment period (ending March 31, 2014) that they were able to reflect on key takeaways and lessons learned from the experience. Furthermore, they were in the midst of planning for the 2015 open enrollment period (beginning November 15, 2014), meaning that they were actively considering and discussing future plans. In this chapter, we review the lessons issuers learned from the first open enrollment period and the changes they anticipate to their programs for future years.

A. Lessons learned during the first open enrollment period

Issuers gained insight into consumer behavior and decision-making processes during the first open enrollment period, though their takeaways on these topics differed. Before open enrollment, issuers knew little about how the Marketplace population might be expected to make purchasing decisions. They said that they now know more about consumer decision making based on enrollment numbers and premium pricing, although they drew markedly different lessons regarding how premium prices affect behavior: some thought their expectations had been met regarding the importance of prices, whereas others were surprised that price was not as dominant as they expected. Three of the 12 issuers offering Marketplace plans (Marketplace-only, CO-OP, and integrated issuers) specifically reported that their expectations regarding the importance of price were met as a “lesson learned”; price was a major consideration among the Marketplace population, which tended to be lower income, and these consumers flocked to the lowest-cost plans. One issuer reported having done consumer research, testing the concepts of price versus consumer choice prior to developing its products, and price

won by two to one. This issuer reported that it did not matter to enrollees who their doctors were, as long as the premium prices offered through the Marketplace were low.

Three other issuers reported that, although they anticipated price would be the most important factor, consumers were savvier shoppers than they expected. Some reported that brand played a role in addition to price, whereas others found consumers choosing more expensive PPOs at higher rates than less expensive HMOs, indicating that provider choice and network flexibility may have been driving factors in their decision-making process. Several issuers noted that new companies offering Marketplace coverage, such as CO-OPs, were at a disadvantage during the first enrollment period due to a lack of brand recognition.

As one Marketplace issuer stated, “We went in with the assumption that price was king. It’s important, but it’s not the only thing that matters. Brand matters. Shoppers are a bit savvier than we had thought.”

The premium costs in the Marketplace were a big unknown during the first open enrollment period, and issuers noted some surprises regarding how their competitors set prices. One noted that the CO-OP issuer in the Marketplace set rates incredibly low, which drew many enrollees, but this competitor speculated that the rates the CO-OP offered were unsustainable and eventually would balance out. In other market areas, however, the CO-OPs noted that they were unable to compete on price, at least in the first year, due to limited capital reserves. In these market areas, the CO-OPs said that they felt the dominant issuer set prices uncompetitively low, raising concerns about market monopolies. One voiced concern that the low prices set by dominant issuers in the Marketplace would scare away other competition in the future.

Despite the multipronged outreach strategies conducted in anticipation of and during the first open enrollment period, gaps in consumer education remain. Three of the 12 issuers offering some kind of Marketplace product expressed concern that consumers purchased plans without understanding the benefits the plans covered, the cost-sharing mechanisms required, or which providers they could visit; these issuers said that consumer lack of understanding was one of their lessons learned. In particular, they saw the difference between metal levels as an important area that will require further education during the next open enrollment period. They felt that individuals had purchased plans without knowing or understanding what they got. As one issuer stated, “There’s also never enough education. There needed to be more opportunities to educate people around the metallic levels. I don’t know [whether] that was done appropriately.” Although premium prices are important, some issuers noted that consumers needed to be educated to look at more than just monthly premiums, as health insurance requires other types of payment beyond the sticker price. Even once consumers enrolled, one issuer noted that they needed additional education; the Marketplace population is not a typical commercial population, and some enrollees required stronger case management than issuers anticipated.

One CO-OP commented, “The price equation is going to adjust itself at some point in order to balance out the levers of co-pays and deductibles. There has to be a total cost view, rather than just focusing on a monthly premium price. The American public will have to become more astute purchasers of health insurance before that can happen.”

In addition, one issuer pointed out that providers were a key demographic who should receive additional education on the Affordable Care Act and how the changes affected them and their practices directly. “The other thing that we learned is that the provider community is very confused. They think [the Marketplace] is another government insurance program like Medicare and Medicaid, not an exchange. We should have done more outreach about what [it] was and what it meant for them.” Although only one issuer discussed this as a lesson learned, it may be a broader issue for others as well (and possibly an area for further research).

Although most issuers were able to speak only hypothetically about how transitions across programs were expected to occur, they recognized this as an important consideration moving forward and one on which the government and issuers needed to focus now that the first open enrollment period has closed. Issuers observed that the manual (as opposed to automatic) nature of the current transition process was a drawback of the present system, and that policymakers and issuers alike need to think more about how to better integrate the Marketplace and Medicaid/CHIP. One issuer offering coverage through both the Marketplace and Medicaid/CHIP commented that the back-end processes were difficult, and there would be a period of time at the point of transition when the issuer would not know in which program a consumer had landed. If a member moved from Medicaid/CHIP to the Marketplace, the issuer would be unable to collect the premiums required in the Marketplace during the first month or so of the member’s enrollment. This issuer commented that it would not recoup those premiums from the consumer, since failure to pay during this time period would not be the consumer’s fault. At least one state in our study sample is convening weekly user group meetings at which issuers can raise these types of concerns regarding transitions and other issues.

In general, issuers recognized that transitioning between programs is the new reality for many consumers and they need to ensure that their systems are set up to handle those transitions efficiently. For issuers offering coverage through both the Marketplace and Medicaid/CHIP, this required a shift in thinking toward considering the two as complementary programs. Another suggestion for how to better integrate the two programs was to encourage issuers offering only Medicaid/CHIP to participate in the Marketplace; issuers viewed streamlining the application and harmonizing the systems and processes as the best ways to ease the burden of participating in both.

A Medicaid/CHIP issuer commented, “The churn population is the next generation of the Affordable Care Act. We need to be thinking about the [Marketplace] as a complement to Medicaid and not as two separate products.”

B. Anticipated changes for future open enrollment periods

When asked what changes they were making based on lessons learned during the first open enrollment period, no issuers reported plans to leave the Marketplace or Medicaid/CHIP; in fact, the majority of Marketplace-only and Medicaid/CHIP-only issuers interviewed reported that they were considering entering the corresponding program in future years. Of the eight issuers currently in the Marketplace (four Marketplace-only and four CO-OP), five reported considering entering the Medicaid/CHIP market (although not imminently), and two reported that they were not considering it (one issuer attributed this to a lack of capital, but noted that if the right partner were to make an approach, it would consider this option). Among Medicaid/CHIP issuers, four of six noted that they were interested in

participating in the Marketplace. Some were taking a “wait and see” approach to see how things shook out in their respective markets (such as the size of enrollment, the identity of the competition, and how premium prices were settling), but even these issuers noted that it would be an appealing market to enter.

Although no issuers reported that their states were adding incentives or streamlining processes to make entering the complementary program more appealing, those issuers considering this move said it would make sense from both business and member perspectives. Issuers expected that new entrants to both the Marketplace and Medicaid/CHIP, particularly those already participating in the other program, would have a positive impact on consumers’ continuity-of-care prospects at the point of transition. As found in the provider network study, issuers offering coverage through both programs have higher degrees of network overlap than those in just one.

In addition to joining the corresponding program, issuers offered generic suggestions for improving integration between programs, including longer-term increases to Medicaid provider reimbursement rates, creating a fee schedule within the Marketplace (similar to those of Medicaid and Medicare) to balance rates, and better aligning Marketplace and Medicaid/CHIP benefits.

For the 2015 plan year, Marketplace issuers reported making changes to product design and premiums in response to lessons learned during the first open enrollment. Medicaid/CHIP issuers said they were not making corresponding changes; given that the Marketplace is a new program and that Medicaid/CHIP has a much longer history, this is not surprising. With the first open enrollment period ended, issuers now have a better idea about the typical consumer enrolling in Marketplace products. Several issuers reported creating more custom products better tailored to the type of member who enrolled in their plans. For example, one issuer is planning to offer a product that allows out-of-state utilization (this issuer is located in an area close to a state border and thought this would provide its enrollees with additional options), and another is excluding certain nonrequired benefits in certain plans to drive premium costs lower because it views price as a driving factor for consumers. Because benefits on the Marketplace are well structured, a few issuers noted that they were attempting to set their products apart by offering more innovative products next year. For example, one issuer plans to increase its health, wellness, and nutrition benefits by offering consumers credit at local grocery stores for every dollar spent on produce. Another is trying to incorporate more innovative concepts, such as e-visits and other technology tools that consumers can use to interact with providers outside of traditional office visits.

One issuer reported planning changes to its provider networks in response to the expectation that more enrollees would be enrolling during the next open enrollment period. Although only one issuer mentioned this prospect, others reported constantly amending and modifying provider networks, so this may be more of an ongoing maintenance feature than a specific goal for the next open enrollment period.

IX. CONCLUSIONS

We conducted interviews with health insurance issuers after the end of the first open enrollment period to understand the decisions issuers made when responding to the Affordable Care Act, their perceptions of related federal and state regulations, and how those decisions and perceptions may affect the continuity of care of individuals transitioning between programs. Due to the timing of the interviews (May–July 2014), respondents already had some time to reflect on the first open enrollment period before we spoke to them and had already begun considerable planning for the 2015 plan year. Below, we discuss the study’s key findings and their potential implications for each research question (Section A), and offer some concluding remarks (Section B).

A. Key findings

1. How and why do health insurance issuers decide whether to participate in the Marketplace, Medicaid, and CHIP? (Chapter III)

Most existing issuers chose to offer coverage through the Marketplace because it “made sense,” deciding early on to participate before (and regardless of) state decisions about participating in the Medicaid expansion or the type of Marketplace offered. CO-OP issuers, which were a new type of firm permitted by the Affordable Care Act, had diverse origins, but all were created with the common goal of offering consumers a new type of affordable insurance option that provided enrollees with a voice in their coverage. Issuers participating in both the Marketplace and Medicaid/CHIP reported that their participation in both programs was strategic, benefitting individuals transitioning across programs and providers participating in their networks, and anticipated that it would benefit their own companies’ bottom line. However, they cited several disadvantages to participating in both programs, including resource constraints, reimbursement rates, and problems with claims payments.

None of the states covering the study’s market areas offer incentives to encourage program participation, although Maryland requires commercial issuers with a large enough market share to participate in the Marketplace, and New York encouraged initial participation by prohibiting issuers from entering the Marketplace for up to two years if they did not participate in 2014. Several issuers offered suggestions that might improve participation in both Medicaid/CHIP and the Marketplace, such as expanding value-based purchasing, extending longer contract periods to issuers, and doing more to require or encourage Medicaid/CHIP issuers to participate in the Marketplace.

2. How are provider networks developed, and what decisions do issuers make that promote or hinder provider network overlap? (Chapter IV)

The provider network development issue is mainly for Marketplace issuers: all six Medicaid/CHIP issuers interviewed reported that their networks had been established for many years and that, at this point, active provider recruitment was quite limited. Among the 12 Marketplace issuers interviewed, the eight previously existing issuers modified their existing commercial or Medicaid/CHIP networks; for some, these modifications entailed recruiting additional ECPs to comply with Marketplace network adequacy standards, whereas for others,

they resulted in limiting the network to create a cost-competitive product. Using existing commercial networks to create a Marketplace network will lead to potentially higher degrees of overlap between the Marketplace and commercial networks, but not necessarily between the Marketplace and Medicaid/CHIP. Among four newly created CO-OP issuers, most chose to lease existing networks from other sources rather than build their own, at least for the first year. Two of these issuers leased a Medicaid/CHIP network or worked closely with a Medicaid/CHIP issuer when building a Marketplace network; such efforts will tend to boost network overlap across programs, thereby maximizing continuity of care for enrollees.

Issuers offering products across programs recognized that offering overlapping networks benefits members, providers, and even the business itself. Despite recognizing these benefits, very few issuers reported that they conducted any kind of internal network overlap analysis; in general, issuers were concerned with meeting network adequacy standards rather than focusing on the percentage of physicians participating in each program. Issuers with high degrees of network integration tended to contract using an “all-products” approach, meaning that providers were encouraged (but generally not required) to participate in all lines of business, and issuers set up contracting mechanisms for the Marketplace to mirror those of their other product lines. Although some offered an “all-products” approach to contracting, issuers with lower degrees of integration noted that this lower network integration may have developed out of the historically separate networks and contracting processes for commercial and Medicaid/CHIP networks.

3. How do issuers respond to and perceive those policies having the following aims:

a. Use marketing, outreach, and education to help consumers learn about Marketplace, Medicaid, and CHIP products and programs? (Chapter V)

The knowledge consumers possess at the point of enrollment influences their ability to make informed choices that will maximize prospects for continuity of care. Marketing, outreach, and enrollment assistance are the main ways consumers learn about the health insurance options available to them through these programs. Marketing and outreach activities for the Marketplace generally are regulated at the state level; all six states in our study have rules regarding fair and accurate marketing practices. The federal government regulates Medicaid issuers’ ability to market their products, and most of our study states require issuers to comply with additional regulations. Although the regulations differ across programs and states, marketing and outreach strategies appear quite similar across issuers regardless of the program or market area, and include mass media campaigns, participation in community events and health fairs, and partnering with community providers to raise awareness.

In addition to learning about products and programs through marketing and outreach, the enrollment assistance offered to consumers provides another avenue for member education. Consumers have access to enrollment assistance through trained Navigators and CACs, as well as through issuers’ individual member services departments. Issuers also offer potential enrollees provider network directories (generally online, although occasionally in hard copy) to help them make informed choices when selecting plans, although some noted that consumers could benefit from receiving additional information to that end, such as counseling on the types of benefits offered through different products or the definition of different metal levels.

**b. Set provider network adequacy standards and monitor network compliance?
(Chapter VI)**

All health insurance issuers are required to meet certain network adequacy standards to ensure that enrollees have access to a sufficient number and geographic distribution of providers. The Affordable Care Act established new federal network adequacy standards for Marketplace issuers, including requiring them to offer networks sufficient in numbers and types of providers, and that include ECPs. States have a great deal of flexibility in interpreting the regulations, however, and three of the six states in the study (California, Illinois, and New York) have adopted network adequacy standards that go beyond the federal minimum.

Issuers that offered plans in multiple programs reported that the network adequacy standards are generally similar between the Marketplace and Medicaid/CHIP, although some perceived the Medicaid/CHIP standards as more straightforward. The requirement to include ECPs in Marketplace networks was not an issue for existing Medicaid/CHIP issuers that entered the Marketplace, but some existing commercial issuers that entered the Marketplace cited this as an issue. CO-OP issuers reported some additional challenges. Issuers across products use similar processes for monitoring network adequacy internally, including Geoaccess software, to ensure that they are meeting time and distance requirements. Although the Medicaid/CHIP issuers were clear about how the state monitored their network adequacy, one issuer offering coverage through both programs expressed a lack of understanding about how the state was using the Marketplace data submitted to monitor network adequacy.

Issuers are required to make their provider network directories available online to potential enrollees and reported updating these directories frequently—weekly, if not daily. Issuers found inaccuracies in Marketplace provider network directories posted on state-based Marketplace websites in 2014, and consumers generally needed to access these materials from the issuer’s website directly. If a network does not include the provider in which a member is interested, the member can make a request, and issuers track those member grievances. Some reported making attempts either to recruit those providers or preapprove visits, if applicable.

**4. How are systems set up to handle transitions between programs, and what policy mechanisms could help ease disruptions in coverage or care during these transitions?
(Chapter VII)**

Millions of individuals will transfer between Medicaid and a Marketplace QHP in 2014. For adults in those states expanding Medicaid eligibility, these transitions will occur when they report income fluctuations above and below 138 percent of the federal poverty level or when their family size changes. For children, the income level at which they must transition will vary, as Medicaid and CHIP eligibility levels vary across states (and within states, across ages). Transitioning between Medicaid/CHIP and Marketplace coverage may create breaks in covered benefits, lack of access to the same primary care physicians, and other continuity-of-care concerns.

Issuers expressed concern that the transition process is not well coordinated and will result in continuity-of-care disruptions. Because they are aware of potential problems, those who offer products across programs are taking steps to encourage consumers to stay with the same issuer at

the point of transition, whereas others are encouraging consumers to make informed decisions that will enable them to maximize continuity of care. Navigators, CACs, and issuers all offer consumers assistance at the point of transition; the types of assistance offered to someone transitioning into an issuer's plan are very similar to those offered at the point of enrollment and may be useful in helping consumers to identify their best prospects for continuity of care. Issuers noted that the lack of coordination in systems and processes across programs at the state level may contribute to transition challenges. By virtue of the way the programs are designed and administered, issuers currently treat the programs as relatively distinct.

Policy mechanisms that can improve coverage and care continuity at the point of transition include continuity-of-care rules, which help ensure smooth coverage transitions for individuals with serious medical conditions, and bridge plans, which are Marketplace plans specifically catering to those transitioning from Medicaid/CHIP. Issuers reported that they are in compliance with continuity-of-care rules (which vary by state), and several go beyond to ensure those transitioning in the midst of a course of treatment do not have interruptions in care at the point of transition. California is the only state in the sample that has passed bridge plan legislation, although it has not yet been implemented. Issuers were uncertain as to whether adopting a bridge plan would, in fact, be feasible given the operational and financial constraints of the program.

5. What major lessons did issuers learn during the first open enrollment period, and how are those lessons influencing their future planning? (Chapter VIII)

Marketplace issuers reported gaining some insight into consumer behavior and decision-making processes during the first open enrollment period but drew different conclusions about the importance of price and provider choice. All of them reported going into the first open enrollment period thinking that “price was king”—some issuers found this assumption validated, whereas others were surprised at the number of consumers who, based on their purchasing decisions, made their selections based on brand, quality, or other factors. The premium costs in the Marketplace were a big unknown during the first open enrollment period, and issuers encountered some surprises regarding how their competitors set prices. Over time, they expect premium prices to stabilize, although not in the near term.

Despite the multipronged outreach strategies conducted in anticipation of and during the first open enrollment period, gaps in consumer and provider education remain. Although most issuers could speak only hypothetically about how they expected transitions across programs to occur, they recognized this as an important consideration moving forward, and one upon which both the government and issuers should be focusing now that the first open enrollment period has closed.

None of the issuers interviewed reported plans to reduce their insurance offerings in future years. In fact, when asked what changes they were making based on what they learned during the first open enrollment period, the majority of Marketplace-only and Medicaid/CHIP-only issuers we interviewed reported that they were considering entering the corresponding program in future years. For the 2015 plan year, Marketplace issuers reported making changes to product design and premiums in response to lessons learned during the first open enrollment; Medicaid/CHIP issuers were not making any corresponding changes.

B. Concluding remarks

Decisions issuers make in response to the Affordable Care Act and subsequent regulations—such as whether to offer coverage through the Marketplace, Medicaid, or CHIP; what plans to offer; how to build provider networks; and the cost of premiums—are critical to whether the law will maximize coverage and offer previously uninsured or underinsured individuals access to high quality coverage. Individuals at the margins of eligibility for the Marketplace (those nearest 138 percent of the federal poverty level) are expected to transition frequently between Marketplace and Medicaid/CHIP eligibility, and the choices issuers make will affect the ease of transition for these individuals. Decisions made by individuals also affect their ability to transition smoothly across programs, such as the issuer and policy they select initially, whether they understand how to use their coverage to obtain care when needed, and learning how to maintain their insurance coverage and providers when income or family circumstances change. Most issuers we interviewed recognized and voiced concerns about continuity-of-care issues at the point of transition, but said it was too early for many enrollees to have transitioned across programs. During the next year, millions of lower income individuals and families will transition between the Marketplace and Medicaid/CHIP, meaning monitoring the transition processes and subsequent effects on continuity of care will be of critical importance.

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APPENDIX A

ADDITIONAL TABLES

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Table A.1. Characteristics of issuers, by market area

Health insurance issuer	Offers insurance in:			Geographic location	Type of ownership	Products offered	
	Marketplace	Medicaid/CHIP	Protocol category			HMO (POS)	PPO (EPO)
Chicago							
Aetna	X		Marketplace-only	National	For profit		X
Blue Cross Blue Shield of Illinois	X		Marketplace-only	Local	Not for profit	X	X
Coventry Health Care	X		Marketplace-only	National	For profit		X
Family Health Network		X	Medicaid/CHIP-only	Local	Not for profit	X	
Harmony Health Plan		X	Medicaid/CHIP-only	Local	For profit	X	
Humana	X		Marketplace-only	National	For profit	X	X
Illinois Health Connect		X	Medicaid/CHIP-only	Local	Government	X	
Land of Lincoln Mutual Health Insurance Co.	X		Marketplace-only CO-OP	Local CO-OP	Not for profit		X
Meridian Health Plan		X	Medicaid/CHIP-only	Local	For profit	X	
Phoenix							
Aetna	X		Marketplace-only	National	For profit		X
AZ Department of Economic Security		X	Medicaid/CHIP-only	Local	Government	X	
Blue Cross Blue Shield of Arizona, Inc.	X		Marketplace-only	Local	Not for profit		X
Care1st		X	Medicaid/CHIP-only	National	Not for profit	X	
Cigna Health and Life Insurance Company	X		Marketplace-only	National	For profit		X
Health Choice	X	X	Marketplace and Medicaid/CHIP: Low Integration	Local	For profit	X	
Health Net	X	X	Marketplace and Medicaid/CHIP: Low Integration	National	For profit	X	X
Humana Health Plan	X		Marketplace-only	National	For profit	X	
Meritus Health Partners	X		Marketplace-only CO-OP	Local CO-OP	Not for profit	X	X
Phoenix Health Plan		X	Medicaid/CHIP-only	Local	Not for profit	X	
UnitedHealthcare		X	Medicaid/CHIP-only	National	For profit	X	
University of Arizona Health Plans	X	X	Marketplace and Medicaid/CHIP: High Integration	Local	Government	X	
Louisville							
Anthem	X		Marketplace-only	National	For profit		X
Coventry Health and Life Insurance Company		X	Medicaid/CHIP-only	National	For profit	X	
Humana	X	X	Marketplace and Medicaid/CHIP: Low Integration	National	For profit	X	
KY Health Cooperative	X		Marketplace-only CO-OP	Local CO-OP	Not for profit		X
Passport Health Plan		X	Medicaid/CHIP-only	Local	Not for profit	X	
WellCare		X	Medicaid/CHIP-only	National	For profit	X	
Baltimore							
Amerigroup		X	Medicaid/CHIP-only	National	For profit	X	

Table A.1 (continued)

Health insurance issuer	Offers insurance in:			Geographic location	Type of ownership	Products offered	
	Marketplace	Medicaid/CHIP	Protocol category			HMO (POS)	PPO (EPO)
CareFirst Blue Cross Blue Shield	X		Marketplace-only	Local	Not for profit	X	X
Evergreen Health Cooperative	X		Marketplace-only CO-OP	Local CO-OP	Not for profit	X	
Maryland Physicians Care		X	Medicaid/CHIP-only	Local	Not for profit	X	
MedStar Family Choice		X	Medicaid/CHIP-only	Local	Not for profit	X	
Priority Partners		X	Medicaid/CHIP-only	Local	Not for profit	X	
Riverside Health		X	Medicaid/CHIP-only	Local	Not for profit	X	
United Healthcare	X	X	Marketplace and Medicaid/CHIP: Low Integration	National	For profit	X	
Buffalo							
American Progressive (Today's Options NY)	X		Marketplace-only	Local	For profit		X
Fidelis Care / Fidelis	X	X	Marketplace and Medicaid/CHIP: High Integration	Local	Not for profit	X	
Health Republic Insurance (Freelancers)	X		Marketplace-only CO-OP	Local CO-OP	Not for profit		X
HealthNow New York, Inc.	X	X	Marketplace and Medicaid/CHIP: High Integration	Local	For profit	X	X
Independent Health Association	X	X	Marketplace and Medicaid/CHIP: High Integration	Local	Not for profit	X	
Univera Healthcare	X	X	Marketplace and Medicaid/CHIP: High Integration	Local	Not for profit	X	X
East Los Angeles							
Anthem Blue Cross	X		Marketplace-only	National	For profit	X	
Blue Shield of California	X		Marketplace-only	Local	Not for profit		X
Care1st		X	Medicaid/CHIP-only	National	Not for profit	X	
Health Net	X	X	Marketplace and Medicaid/CHIP: Low Integration	National	For profit	X	X
Kaiser Permanente	X	X	Marketplace and Medicaid/CHIP: High Integration	National	Not for profit	X	
L.A. Care Health Plan	X	X	Marketplace and Medicaid/CHIP: Low Integration	Local	Government	X	
Molina Healthcare	X	X	Marketplace and Medicaid/CHIP: Low Integration	National	For profit	X	

Source: Mathematica analysis of data from Alliance for Advancing NonProfit Healthcare 2012 and of publicly available provider directories (January/February 2014).

Note: Only issuers included in the study are listed in this table. Although Anthem also offers Medicaid/CHIP coverage in East Los Angeles, it is not included because no primary care physicians are actually located in the ZIP codes of interest. Likewise, Kaiser Foundation Marketplace Health Plans offers Marketplace coverage in Baltimore; it is not included here because it is primarily based in Washington, DC, with 8 primary care physicians in the Baltimore area. Aetna purchased Coventry Health Care (May 7, 2013) but continues to offer separate products with separate networks; Anthem includes Anthem (KY) and Anthem Blue Cross (CA); Care1st (AZ, CA) is a regional issuer that differs from CareFirst (MD); Coventry Health Care includes Coventry Health and Life Insurance Company (KY) and Coventry Health Care (IL). Mkt = Marketplace; M/C = Medicaid/CHIP; CO-OP = consumer operated and oriented plan; CHIP = Children's Health Insurance Program.

Table A.2. Network adequacy standards and requirements

State	Enrollee/provider ratios	Standard travel time/distance	Appointment wait-time standards
AZ			
Marketplace	No standard ¹	No standard ¹	No standard ¹
Medicaid/CHIP	No standard (but state will notify contracted plans on a quarterly basis if a primary care physician's patient panel totals more than 1,800 Medicaid enrollees). ²	Urban: 5 miles; Rural: no standard. ³	Routine care: 21 days. ³
CA			
Marketplace	Managed care plans: one (1) physician per 1,200 enrollees; one (1) primary care physician per 2,000 enrollees. ³	Managed care plans: 30 miles for primary care and 15 miles for hospitals. ⁴	HMO only: 10–15 days for nonurgent care. ⁴
Medicaid/CHIP	One (1) physician per 1,200 enrollees. ³	Medicaid: Urban: 10 miles. Rural: 10 miles. ³ CHIP: Urban: 15 miles. Rural: 15 miles. ³	Medicaid: Routine care: No standard. ³ CHIP: Routine care: 10 days. ³
IL			
Marketplace	The provider-to-enrollee ratio must be one (1) per 1,000 for primary care physicians. ⁵	In urban areas, the distance from any point in the HMO's service area to a point of service can be no greater than 30–45 miles for primary care. ⁵	No standard ⁵
Medicaid/CHIP ^a	At least one (1) full-time equivalent physician for each 1,200 enrollees, including one (1) full-time equivalent primary care physician for each 2,000 enrollees. ⁶	No standard ⁶	Primary care physicians routine within 5 weeks. ⁶
KY			
Marketplace	No standard ⁷	No standard ⁷	No standard ⁷
Medicaid/CHIP	Primary care physician-to-member ratio not to exceed 1,500:1. ⁸	Delivery sites that are no more than 30 miles/30 minutes for enrollees in urban areas, or 45 miles/45 minutes for enrollees in rural areas. ⁸	Appointment and waiting times not to exceed 30 days from date of a member's request for routine and preventive services. ⁸
MD			
Marketplace	No standard ⁴	No standard ⁴	No standard ⁴

Table A.2 (continued)

State	Enrollee/provider ratios	Standard travel time/distance	Appointment wait-time standards
Medicaid/CHIP	Primary care physician-to-member ratio not to exceed 2,000:1. ³	Urban: 10 miles. Rural: 30 miles. ³	Routine care: 30 days. ³
NY			
Marketplace	The health insurer applicant's network must meet the following: Each county network must include a hospital. The network must provide a choice of three (3) primary care physicians in each county, but more may be required based on enrollment and geographic accessibility. ⁹	Primary care physicians: • Metropolitan areas – 30 minutes by public transportation for primary care physicians; • Nonmetropolitan areas – 30 minutes or 30 miles by public transportation or car for primary care providers; • In rural areas, transportation requirements may exceed these standards, if justified. ⁹	No standard ⁹
Medicaid/CHIP	No more than 1,500 enrollees can be assigned to each physician, or 2,400 enrollees for a physician practicing in combination with a registered physician assistant or certified nurse practitioner. ³	Medicaid: Urban: 30 miles. Rural: No standard. ³ CHIP: Urban: 30 minutes. Rural: 30 minutes. ³	Routine care: 28 days. ³

Note: This table lists specific network adequacy standard requirements for Marketplace, CHIP, and Medicaid plans. Marketplace QHPs must also comply with any state standards in place prior to the Affordable Care Act, as well as any additional standards that states set in conducting plan management for the Marketplace.

Sources: ¹State of Arizona 2012, ²Bachrach et al 2011, ³Office of the Assistant Secretary for Planning and Evaluation 2012, ⁴McCarty and Farris 2013, ⁵Illinois Division of Insurance 2014, ⁶Illinois Department of Healthcare and Family Services 2014, ⁷900 KAR 10:010E, ⁸Kentucky Cabinet for Health and Family Services 2011, ⁹Office of the New York Health Benefit Exchange 2013.

^aIllinois has different standards for its Medicaid Managed Care Community Network (MCCN) and its Integrated Care Program. However, since the Integrated Care Program is not available in Chicago—our study site—we have included only requirements for the MCCN program in this table.

Table A.3. Continuity of care laws, by state

	Year most recent law enacted	Name of law	Conditions covered and time period coverage is extended (in parentheses)	Issuers affected	When the law applies
Arizona	2000	HB 2600 Managed Care Accountability Act	(1) Life threatening disease or condition (30 days for life threatening disease) (2) Third trimester of pregnancy (delivery through six weeks after delivery)	All managed care plans	When a provider contract with a health plan is terminated, and when an enrollee switches insurance networks
California	2014	Amendment to Section 1373.96 of the Health and Safety Code	(1) Acute condition (for the duration of the condition) (2) Serious chronic condition (through completion of treatment, not to exceed 12 months) (3) Pregnancy (three trimesters and immediate postpartum) (4) Terminal illness (duration of illness, not to exceed 12 months) (5) Care of a newborn, ages birth to 36 months (not to exceed 12 months) (6) Surgery	All health insurance plans	When a provider contract with a health plan is terminated
Illinois	1999	215 ILCS 134 Managed Care Reform and Patient Rights Act	All types of care (90 days, or through postpartum care if an enrollee is in the third trimester of pregnancy when her physician terminates his/her contract)	All managed care plans	When a provider contract with a health plan is terminated, and when an enrollee switches insurance networks
Kentucky	2000	Amendment to KRS 304.17A-527	(1) Inpatient care (through discharge from hospital, or termination of active treatment – whichever is longer) (2) Pregnancy (through post-partum period, if the woman was at least four months pregnant when the provider contract was terminated)	All managed care plans	When a provider contract with a health plan is terminated

Table A.3 (continued)

	Year most recent law enacted	Name of law	Conditions covered and time period coverage is extended (in parentheses)	Issuers affected	When the law applies
Maryland	2013 (Continuity of Care portion of the legislation will go into effect January 1, 2015) 2013 Maryland Code INSURANCE § 15-140 - Provisions for Marylanders transitioning between carriers and between carriers and State programs	Maryland Health Progress Act of 2013 (SB 274/HB 228)	(1) Acute conditions (90 days or the course of treatment, whichever is shorter) (2) Serious chronic conditions (90 days or the course of treatment, whichever is shorter) (3) Pregnancy (three trimesters and post partum) (4) Mental health conditions and substance use disorders (90 days or the course of treatment, whichever is shorter) (5) Any additional condition upon which a provider and insurer agree to provided services (90 days or the course of treatment, whichever is shorter)	All health insurance plans	When an enrollee switches insurance networks
New York	1996	N.Y. Pub. Health L. § 4403(6)(e-f)	(1) When a doctor's contract ends, a patient can continue to see that doctor for: a) up to 90 days for any condition b) through post-partum period if the patient is at least in her second trimester of pregnancy (2) When a patient's coverage changes there is continuing coverage for: a) Life-threatening or degenerative and disabling conditions (60 days) b) The second trimester of pregnancy (through post-partum care)	HMOs only	When a provider contract with a health plan is terminated, and when an enrollee switches insurance networks

Source: National Conference of State Legislatures 2011.

Note: An enrollee in an insurance plan can continue receiving care with a provider who is no longer in-network (either because the patient switched plans, or because the provider's contract has been terminated) for the conditions and time periods listed in this table. The details about continuing coverage vary by state. If the state has enacted more than one continuity-of-care law, the most recent is included. HMO = health maintenance organization.

APPENDIX B

INTERVIEW PROTOCOLS

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Table Shell B.1. Issuer background information

Background
Location?
Protocol?
Issuer?
Type of issuer:
For profit, not-for-profit, or government
Local or national?
Publicly traded?
Offers plans in:
Marketplace?
Medicaid?
CHIP?
Employer sponsored insurance (ESI?)
Other non-Marketplace private insurance?
Length of time offering any health insurance in [Market Area]?

Note: This table shell shows the background information prepared for each issuer prior to the interviews.

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PROTOCOL FOR MARKETPLACE-ONLY ISSUERS, NON-CO-OP

Thanks very much for agreeing to talk with us. We have been funded by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services (HHS) to conduct a small feasibility analysis focusing on continuity of care across Medicaid, the Children’s Health Insurance Program (CHIP), and the new health insurance Marketplaces. We are assessing provider network overlap in six distinct market areas by comparing provider network directories for each of the health insurance plans participating in these programs. In addition, we are interviewing health plan staff in these same market areas to understand the extent of network overlap, plan requirements for provider participation, and key characteristics of provider networks across Medicaid, CHIP and Marketplace plans in each market area. *[If asked: The six market areas of interest were selected based on a set of necessary conditions for participation in the study (adopting the Medicaid expansion and a high Medicaid managed care penetration rate) and represent variation in other characteristics that might be expected to impact the continuity of care an enrollee experiences when switching across Medicaid, CHIP, and/or Marketplace coverage (such as type of Marketplace, geographic region, competitiveness of the individual health insurance market, and average Marketplace premiums.)* The market areas selected include: Phoenix, AZ; East Los Angeles, CA; Chicago, IL; Louisville, KY; Baltimore, MD; and Buffalo, NY.

During our interview today, we will be asking you questions on a range of topics including: decisions about participation in the health insurance Marketplace and Medicaid/CHIP; types of outreach and enrollment being conducted; how you are handling transitions across different health insurance programs; state-level requirements for your provider networks; any concerns you may have related to provider networks; and other continuity of care issues.

Information gathered during our interview will be used in a report that will aggregate and synthesize findings from the provider network directory search as well as interviews across the six market areas. Importantly, none of the information you share with us today will be directly quoted or attributed to you. We’ll be taking notes during our discussion, and with your permission we would also like to record this interview, as a backup to those notes. We will destroy those recordings as soon as we are sure our notes are accurate.

Do you have any questions?

Do we have your permission to record the interview?

I. Background: Issuer Characteristics

[If any incomplete items from our review of public data sources] We’d like to start by confirming some background information about your company. *[Review information in the background information sheet that we could not find through public data sources]*

II. Program Participation and Member Enrollment

Next, I’d like to ask some questions about your company’s decisions to participate in the health insurance Marketplace in **State**.

1. How did your company reach the decision to pursue this new line of business? Did you wait to hear the result of state decisions (for example, on Marketplace type or Medicaid expansion), or did your company decide it would pursue this in this market regardless of those decisions?
2. **[If large, national issuer]** Was the decision to participate in **State's** Marketplace reached locally, or was it decided by your corporate headquarters? Does your company participate in the Marketplaces in all states in which you offer coverage, or only a select few? **[If small, local issuer]** Please tell me a little bit about the considerations your company had when deciding to participate in the insurance Marketplace in **State**.
3. Can you please walk me through the timeline for the Marketplace application process? For example, describe when applications were due, when you were notified you would be participating, and any issues you may have faced?
4. Are there any particular reasons your company has chosen not to offer Medicaid/CHIP coverage in **State**? Is this something you might consider offering in the future?

III. Member Outreach and Enrollment

Now, I'd like to ask some questions about outreach and enrollment.

5. Can you please briefly give a high-level summary of the types of outreach you are conducting for your Marketplace plans, if any? For example, do you conduct any marketing efforts for your Marketplace plans (such as TV or radio ads, or participation at health fairs)?
6. Can you please briefly give a high-level summary of the types of enrollment assistance you offer? Could a potential enrollee call you directly to sign-up for a Marketplace plan, or do they need to enroll through the Marketplace website?
7. Did you experience any issues with the Marketplace website used in your state? If so, please describe the issues and whether/how they have been resolved.
8. Do you anticipate any specific challenges (structural, IT, etc.) regarding individuals transitioning between enrollment in Marketplace and Medicaid/CHIP plans?

IV. Provider Networks

Next, I'd like to ask some questions about recruiting providers and your provider networks.

9. How was your provider network for your Marketplace plans formed? Do you actively recruit providers, or do providers interested in participating approach you?
10. Has recruiting providers to participate in your Marketplace network been a challenge?
11. How do you define Marketplace network adequacy?
 - i. For example, do you set the number of providers by specialty per 1,000 members in each network?
 - ii. For example, do you track requests or complaints from consumers regarding suggestions to enhance your networks?

- iii. For examples, do you use any specific tools to alert you when one of your networks has a low number of providers in a particular specialty or within a geographic area?
12. Does your provider network seem adequate based on the level of Marketplace enrollment thus far? As individuals enroll in coverage, have you identified any particular areas of network strain (such as in provider type or geographic area)?
 13. How would you characterize the degree of provider overlap between Marketplace networks across metal levels?
 14. For consumers, does enrolling in a “higher” metal level result in access to a broader network?
 15. What are your state’s Marketplace network adequacy standards? Did the state align network adequacy standards for qualified health plans (QHPs) with existing state HMO standards?
 16. Are network adequacy standards different depending on plan type (HMO, PPO, EPO, POS)?
 17. What is the process for monitoring and assessing Marketplace plan network adequacy in your state? How frequently is adequacy assessed?
 18. Do you get consumer inquiries about accessing providers not in your network? If so, how are these handled?
 19. How do you publicize information about the composition of your Marketplace networks? Do consumers have access to provider network information prior to enrollment?
 20. What is the average panel size for primary care providers in your Marketplace offerings?
 - i. Does this vary by metal type?
 - ii. Do you have any minimum or maximum standards for the number of members a primary care physician could be responsible for?
 21. How frequently do you update your online provider network directories?
 22. For what length of time do your provider contracts run? How do physicians renew their provider agreements/contracts?

V. Transitions and Continuity of Care

The next series of questions are focused specifically on continuity of care.

23. Does **State** set any standards for Marketplace qualified health plans to support continuity of care when an enrollee transitions between programs, such as between the Marketplace and Medicaid?
 - i. For example, when someone new enrolls in one of your plans, are there any requirements to accept prior authorization determinations from the health plan they transitioned from? If so, for what treatments and for what time period?
 - ii. When someone new enrolls in one of your plans, are there any requirements to allow individuals within specified courses of treatment to receive care from out-of-network providers for a specified period of time?

24. Do you offer any related continuity of care provisions beyond what Marketplace regulations require?

VI. Wrap-Up and Lessons Learned

I have just a few more overarching questions for you.

25. Given that benefits and cost-sharing are standardized across plans, how does your company differentiate your plans on the Marketplace?

26. Has the level of competition in [**Market Area**] met your expectations? Has anything surprised you about which issuers are participating and which aren't?

27. What have been the major lessons learned thus far regarding the Marketplace in **State**?

28. Do you see any particular disadvantages to participating in both programs?

Is there anything else you'd like to add to our conversation? Thank you very much for your time.

PROTOCOL FOR MARKETPLACE-ONLY ISSUERS, CO-OP

Thanks very much for agreeing to talk with us. We have been funded by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services (HHS) to conduct a small feasibility analysis focusing on continuity of care across Medicaid, the Children’s Health Insurance Program (CHIP), and the new health insurance Marketplaces. We are assessing provider network overlap in six distinct market areas by comparing provider network directories for each of the health insurance plans participating in these programs. In addition, we are interviewing health plan staff in these same market areas to understand the extent of network overlap, plan requirements for provider participation, and key characteristics of provider networks across Medicaid, CHIP and Marketplace plans in each market area. *[If asked: The six market areas of interest were selected based on a set of necessary conditions for participation in the study (adopting the Medicaid expansion and a high Medicaid managed care penetration rate) and represent variation in other characteristics that might be expected to impact the continuity of care an enrollee experiences when switching across Medicaid, CHIP, and/or Marketplace coverage (such as type of Marketplace, geographic region, competitiveness of the individual health insurance market, and average Marketplace premiums.)* The market areas selected include: Phoenix, AZ; East Los Angeles, CA; Chicago, IL; Louisville, KY; Baltimore, MD; and Buffalo, NY.

During our interview today, we will be asking you questions on a range of topics including: decisions about participation in the health insurance Marketplace and Medicaid/CHIP; types of outreach and enrollment being conducted; how you are handling transitions across different health insurance programs; state-level requirements for your provider networks; any concerns you may have related to provider networks; and other continuity of care issues.

Information gathered during our interview will be used in a report that will aggregate and synthesize findings from the provider network directory search as well as interviews across the six market areas. Importantly, none of the information you share with us today will be directly quoted or attributed to you. We’ll be taking notes during our discussion, and with your permission we would also like to record this interview, as a backup to those notes. We will destroy those recordings as soon as we are sure our notes are accurate.

Do you have any questions?

Do we have your permission to record the interview?

I. Background: Issuer Characteristics

[If any incomplete items from our review of public data sources] We’d like to start by confirming some background information about your company. *[Review information in the background information sheet that we could not find through public data sources]*

II. Program Participation

Next, I’d like to ask some questions about your company’s decisions to participate in the health insurance Marketplace in **State**.

1. CO-OPs are a new type of insurance plan initiated by the Affordable Care Act. How was your plan formed? Who took the lead in organizing it?
2. Did State offer any incentives or take any specific steps to encourage CO-OP plans to form and to participate in the Marketplace? If so, what did they do and did these incentives influence your decision to participate?
3. How would you describe the Marketplace application process? Are there any improvements you would recommend for the future?
4. Did you consider (or would you ever consider) offering Medicaid/CHIP coverage through your CO-OP plan? What, if any, incentives might be offered that would influence your decision?

III. Member Outreach and Enrollment

Now, I'd like to ask some questions about outreach and enrollment.

5. As a new health insurance issuer, have you conducted any specific outreach efforts to raise public awareness or recognition of your plan?
6. Does being structured as a CO-OP plan offer any particular advantages in terms of outreach and/or enrollment?
7. How would you characterize your early Marketplace enrollment experiences?

IV. Provider Networks

Next, I'd like to ask some questions about recruiting providers and your provider networks.

8. As a new plan, how did you go about recruiting providers to your Marketplace network? Did anything surprise you about the recruitment process?
9. Do your Marketplace networks vary by metal level? If so, how is it determined which providers participate in which networks?
10. Do you have any specific concerns related to your Marketplace provider network? For example, do you worry about not having providers in certain geographic areas, or having limited numbers of certain specialties?
11. What requirements are in place for Marketplace plans to contract with safety net providers or essential community providers?
12. Do you require a primary care provider to be chosen at enrollment? How does auto-assignment work?
13. How often do you check to see if Marketplace providers are accepting new patients? Do you set any rules for when a physician is required to accept new patients?

V. Transitions and Continuity of Care

The next series of questions are focused specifically on continuity of care.

14. Do you have any specific continuity of care requirements incorporated into your plan's structure?

15. Do you undertake any specific efforts to encourage individuals that are enrolling in your plans to keep their previous primary care provider?
16. What, if any, reimbursement for services do you provide if a member sees an out-of-network doctor?
17. Do you have any concerns with the system or process when individuals need to transition from Marketplace coverage to Medicaid/CHIP coverage (or vice versa)? If so, what are they?
18. Do you have any concerns about continuity of care for members when transitioning across programs?

VI. Wrap-Up and Lessons Learned

I have just a few more overarching questions for you.

19. What do you think attracts Marketplace consumers to enroll in a CO-OP plan?
20. What have been the major lessons learned thus far regarding CO-OP plans in the Marketplace?
21. Knowing what you know now, would you make any changes to your plan's structure or organizational system?

Is there anything else you'd like to add to our conversation? Thank you very much for your time.

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PROTOCOL FOR MEDICAID/CHIP-ONLY ISSUERS

Thanks very much for agreeing to talk with us. We have been funded by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services (HHS) to conduct a small feasibility analysis focusing on continuity of care across Medicaid, the Children’s Health Insurance Program (CHIP), and the new health insurance Marketplaces. We are assessing provider network overlap in six distinct market areas by comparing provider network directories for each of the health insurance plans participating in these programs. In addition, we are interviewing health plan staff in these same market areas to understand the extent of network overlap, plan requirements for provider participation, and key characteristics of provider networks across Medicaid, CHIP and Marketplace plans in each market area. *[If asked: The six market areas of interest were selected based on a set of necessary conditions for participation in the study (adopting the Medicaid expansion and a high Medicaid managed care penetration rate) and represent variation in other characteristics that might be expected to impact the continuity of care an enrollee experiences when switching across Medicaid, CHIP, and/or Marketplace coverage (such as type of Marketplace, geographic region, competitiveness of the individual health insurance market, and average Marketplace premiums.)* The market areas selected include: Phoenix, AZ; East Los Angeles, CA; Chicago, IL; Louisville, KY; Baltimore, MD; and Buffalo, NY.

During our interview today, we will be asking you questions on a range of topics including: decisions about participation in the health insurance Marketplace and Medicaid/CHIP; types of outreach and enrollment being conducted; how you are handling transitions across different health insurance programs; state-level requirements for your provider networks; any concerns you may have related to provider networks; and other continuity of care issues.

Information gathered during our interview will be used in a report that will aggregate and synthesize findings from the provider network directory search as well as interviews across the six market areas. Importantly, none of the information you share with us today will be directly quoted or attributed to you. We’ll be taking notes during our discussion, and with your permission we would also like to record this interview, as a backup to those notes. We will destroy those recordings as soon as we are sure our notes are accurate.

Do you have any questions?

Do we have your permission to record the interview?

I. Background: Issuer Characteristics

[If any incomplete items from our review of public data sources] We’d like to start by confirming some background information about your company. *[Review information in the background information sheet that we could not find through public data sources]*

II. Program Participation

Next, I’d like to ask some questions about your company’s decisions to participate in Medicaid and/or CHIP in **State**.

1. Does **State** offer any incentives or take any specific steps to encourage issuers to participate in Medicaid and/or CHIP? If so, what kinds of things do they do and did these incentives influence your decision to participate?
2. Are there any incentives that **State** could adopt that might encourage broader issuer participation in the Medicaid/CHIP market?
3. Did your company consider participating in the Marketplace in **State**? Why or why not? [**If it did consider participating,**] Did you apply to offer QHPs on the Marketplace? [**If it did not consider participating,**] Why did you ultimately decide not to pursue this new line of business?

III. Member Outreach and Enrollment

Now, I'd like to ask some questions about outreach and enrollment.

4. Can you please briefly give a high-level summary of the types of outreach you conduct for your Medicaid/CHIP plans, if any? For example, do you conduct any marketing efforts for your plans (such as TV or radio ads, or participation at health fairs)?
5. Can you please briefly give a high-level summary of the types of enrollment assistance you offer? Could a potential enrollee call you directly to sign-up for a plan, or do they need to enroll through the state website?

VI. Provider Networks

Next, I'd like to ask some questions about recruiting providers and your provider networks.

6. How is your Medicaid/CHIP provider network formed? In general, do you approach potential providers to determine whether they are interested in participating, or do providers approach you?
7. Is recruiting providers to participate in your Medicaid/CHIP network a challenge? If so, what do you see as the primary challenges (reimbursement, paperwork requirements, other issues)?
8. [**If offering other (non-Marketplace) coverage**] Is recruitment different for your Medicaid/CHIP network than for your other private networks? If so, how?
9. How do you define Medicaid/CHIP network adequacy?
 - i. For example, do you set the number of providers by specialty per 1,000 members in each network?
 - ii. For example, do you track requests or complaints from consumers regarding suggestions to enhance your networks?
 - iii. For example, do you use any specific tools to alert you when one of your networks has a low number of providers in a particular specialty or within a geographic area?
10. Do you have any specific concerns related to your Medicaid/CHIP provider network? For example, do you worry about not having providers in certain geographic areas, or having limited numbers of certain specialties?

11. In general, has your provider network in [**Market Area**] faced any strain with the influx of newly-insured people? For example, has the ratio of members to primary care providers increased?
12. What is the process for monitoring and assessing Medicaid/CHIP plan network adequacy in your state? How frequently is adequacy assessed?
13. What requirements are in place for Medicaid and/or CHIP plans to contract with safety net providers or essential community providers?
14. Do you require a primary care provider to be chosen at enrollment? How does auto-assignment work?
15. Do you get consumer inquiries about accessing providers not in your network? If so, how are these handled?
16. How do you publicize information about the composition of your Medicaid/CHIP networks? Do consumers have access to provider network information prior to enrollment?
17. What is the average panel size for primary care providers in your Medicaid/CHIP network? Do you have any minimum or maximum standards for the number of members a primary care physician could be responsible for?
18. How frequently do you update your Medicaid/CHIP provider network directories?
19. For what length of time do your Medicaid/CHIP provider contracts run? How do physicians renew their provider agreements/contracts?
20. Do you set any rules for when a physician is required to accept new patients? How often do you check to see if providers are accepting new patients?

V. Transitions and Continuity of Care

In this series of questions, we want to understand what happens when members move from one program to another and related issues regarding continuity of care.

21. If an individual who was enrolled in one of your plans is determined to be no longer eligible for Medicaid/CHIP, please walk me through the steps that occur when someone needs to enroll in a Marketplace plan. If you have not experienced any transitions yet, please feel free to comment on how you expect that the process will work.
 - i. What information are you required to share, and with whom?
 - ii. How are the systems set-up to handle these transitions?
 - iii. Have you found any issues at the point of transition?
22. If an individual was enrolled in Marketplace coverage and becomes eligible for Medicaid/CHIP, does the reverse process have any different challenges?
23. Does **State** set any standards for Medicaid/CHIP plans to establish continuity of care when an enrollee transitions between programs?
 - i. For example, when someone new enrolls in one of your plans, are there any requirements to accept prior authorization determinations from the health plan they transitioned from? If so, for what treatments and for what time period?

- ii. When someone new enrolls in one of your plans, are there any requirements to allow individuals within specified courses of treatment to receive care from out-of-network providers for a specified period of time?

24. Do you offer any related continuity of care provisions beyond what is required by regulations?
25. What, if any, reimbursement for services do you provide if a member sees an out-of-network doctor?

VI. Wrap-Up and Lessons Learned

I have just a few more overarching questions for you.

26. Are you currently planning any meaningful changes to your Medicaid/CHIP product lines for 2015? For example, changes to your plan offerings, provider networks, etc.
27. Is your company considering participating in the Marketplace in the future? If so, what will drive that decision?

Is there anything else you'd like to add to our conversation? Thank you very much for your time.

PROTOCOL FOR MARKETPLACE AND MEDICAID/CHIP ISSUERS WITH HIGH-INTEGRATION NETWORKS

Thanks very much for agreeing to talk with us. We have been funded by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services (HHS) to conduct a small feasibility analysis focusing on continuity of care across Medicaid, the Children’s Health Insurance Program (CHIP), and the new health insurance Marketplaces. We are assessing provider network overlap in six distinct market areas by comparing provider network directories for each of the health insurance plans participating in these programs. In addition, we are interviewing health plan staff in these same market areas to understand the extent of network overlap, plan requirements for provider participation, and key characteristics of provider networks across Medicaid, CHIP and Marketplace plans in each market area. *[If asked: The six market areas of interest were selected based on a set of necessary conditions for participation in the study (adopting the Medicaid expansion and a high Medicaid managed care penetration rate) and represent variation in other characteristics that might be expected to impact the continuity of care an enrollee experiences when switching across Medicaid, CHIP, and/or Marketplace coverage (such as type of Marketplace, geographic region, competitiveness of the individual health insurance market, and average Marketplace premiums.)]* The market areas selected include: Phoenix, AZ; East Los Angeles, CA; Chicago, IL; Louisville, KY; Baltimore, MD; and Buffalo, NY.

During our interview today, we will be asking you questions on a range of topics including: decisions about participation in the health insurance Marketplace and Medicaid/CHIP; types of outreach and enrollment being conducted; how you are handling transitions across different health insurance programs; state-level requirements for your provider networks; any concerns you may have related to provider networks; and other continuity of care issues.

Information gathered during our interview will be used in a report that will aggregate and synthesize findings from the provider network directory search as well as interviews across the six market areas. Importantly, none of the information you share with us today will be directly quoted or attributed to you. We’ll be taking notes during our discussion, and with your permission we would also like to record this interview, as a backup to those notes. We will destroy those recordings as soon as we are sure our notes are accurate.

Do you have any questions?

Do we have your permission to record the interview?

I. Background: Issuer Characteristics

[If any incomplete items from our review of public data sources] We’d like to start by confirming some background information about your company. *[Review information in the background information sheet that we could not find through public data sources]*

II. Program Participation

Next, I’d like to ask some questions about your company’s decisions to participate in the health insurance Marketplace in **State**.

1. How did your company reach the decision to pursue this new line of business? Did you wait to hear the result of state decisions (for example, on Marketplace type or Medicaid expansion), or did your company decide it would pursue this in this market regardless of those decisions?
2. Did **State** offer any incentives or take any specific steps to encourage existing Medicaid/CHIP issuers to participate in the Marketplace? If so, what do they do and did these incentives influence your company's decision to participate?
3. Are there any additional incentives that **State** could offer that would make participating in the Marketplace or Medicaid/CHIP more appealing to issuers?

III. Member Outreach and Enrollment

Now, I'd like to ask some questions about outreach and enrollment.

4. How does your outreach strategy differ between your Marketplace plans and your Medicaid/CHIP plans? What are some of the main reasons for any differences? For example, are differences driven by state regulations, or company strategy?
5. Does enrollment assistance and customer service offered differ between your Marketplace and Medicaid/CHIP plans? For example, are the help lines the same?

IV. Provider Networks

During the provider network directory search component of this study that I described earlier, we reviewed the primary care providers participating across Marketplace, Medicaid, and CHIP plans for each insurance issuer in **market area**. If a provider participated across all lines of business, they were determined to "overlap" across networks. Through this exercise, we determined your company to have a high degree of overlap across its Marketplace and Medicaid/CHIP networks, meaning 75 percent or more of the primary care physicians in our sample participated across programs. Next, I'd like to ask some questions about recruiting providers to your networks, the composition of your provider networks, and the overlap across networks.

6. What was the process used for establishing your Marketplace network? Did you start with one of your existing networks and reach out to providers to request participation, or did you take a different approach?
7. Was there any intentional effort made to see that the provider networks for the different programs would be similar?
8. As mentioned previously, your networks for primary care doctors across your Marketplace and Medicaid/CHIP plans are fairly well integrated. What do you think contributes to this high integration?
9. What advantages do you see to having highly-integrated networks? Do you see any specific advantages for members, for providers, or from an administrative perspective?
10. Do you take any steps to encourage providers to participate in all lines of business (i.e. Marketplace, Medicaid/CHIP, employer-sponsored and other private insurance plans)?

11. What is the process for recruiting providers to your Medicaid/CHIP networks?
12. What challenges have you faced in forming your provider networks?
13. Does the provider contracting process vary between your Medicaid/CHIP and Marketplace networks? For example, does the length of provider contracts vary?

V. Transitions and Continuity of Care

In this series of questions, we want to understand what happens when members move from one program to another and related issues regarding continuity of care.

14. Do you think members are aware of the level of integration across your networks? Is this something you think members value?
15. If a member is no longer eligible for Medicaid/CHIP coverage and needs to transition to Marketplace coverage (or vice versa), what types of assistance are available to consumers at the point of transition?
16. Your company offers Medicaid, CHIP, and Marketplace plans: do you expect to take any steps to encourage members to stay with plans offered by your company when transitioning across programs? If so, what types of efforts might you make?
17. When an individual transitions between a Medicaid/CHIP plan and a Marketplace plan, do you anticipate undertaking particular efforts taken to encourage them to maintain their primary care provider?
18. **[If California issuer]** Are any of the plans offered by your company “bridge” plans (Marketplace plans that have enrollment limited to consumers transitioning from Medicaid/CHIP coverage to Marketplace coverage, or family members of consumers enrolled in or transitioning from Medicaid/CHIP coverage)? Was this option considered? Why or why not?

VI. Wrap-Up and Lessons Learned

I have just a few more overarching questions for you.

19. What have been some of the major lessons learned thus far with regard to network integration across Medicaid/CHIP and the Marketplace?
20. Do you anticipate your company will continue to participate in these programs in the future?

Is there anything else you’d like to add to our conversation? Thank you very much for your time.

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PROTOCOL FOR MARKETPLACE AND MEDICAID/CHIP ISSUERS WITH LOW INTEGRATION NETWORKS

Thanks very much for agreeing to talk with us. We have been funded by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services (HHS) to conduct a small feasibility analysis focusing on continuity of care across Medicaid, the Children’s Health Insurance Program (CHIP), and the new health insurance Marketplaces. We are assessing provider network overlap in six distinct market areas by comparing provider network directories for each of the health insurance plans participating in these programs. In addition, we are interviewing health plan staff in these same market areas to understand the extent of network overlap, plan requirements for provider participation, and key characteristics of provider networks across Medicaid, CHIP and Marketplace plans in each market area. *[If asked: The six market areas of interest were selected based on a set of necessary conditions for participation in the study (adopting the Medicaid expansion and a high Medicaid managed care penetration rate) and represent variation in other characteristics that might be expected to impact the continuity of care an enrollee experiences when switching across Medicaid, CHIP, and/or Marketplace coverage (such as type of Marketplace, geographic region, competitiveness of the individual health insurance market, and average Marketplace premiums.)]* The market areas selected include: Phoenix, AZ; East Los Angeles, CA; Chicago, IL; Louisville, KY; Baltimore, MD; and Buffalo, NY.

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I. Background: Issuer Characteristics

[If any incomplete items from our review of public data sources] We’d like to start by confirming some background information about your company. *[Review information in the background information sheet that we could not find through public data sources]*

II. Program Participation and Member Enrollment

Next, I’d like to ask some questions about your company’s decisions to participate in the health insurance Marketplace in **State**.

1. What factors contributed to the decision to participate in the Marketplace in **State**?
2. Does **State** offer any incentives or take any specific steps to encourage Marketplace issuers to participate in Medicaid and/or CHIP? If so, what kinds of things do they do?
3. From a member's perspective, how is the enrollment process for your Marketplace plans different from enrollment processes for Medicaid and CHIP plans?

III. Provider Networks

During the provider network directory search component of this study that I described earlier, we reviewed the primary care providers participating across Marketplace, Medicaid, and CHIP plans for each insurance issuer in **market area**. If a provider participated across all lines of business, they were determined to "overlap" across networks. Through this exercise, we determined your company to have a relatively low degree of overlap across its Marketplace and Medicaid/CHIP networks, meaning 60 percent or fewer of the primary care physicians in our sample participated across programs. In your case, the overlap rate was **XX.X percent**. Next, I'd like to ask some questions about recruiting providers to your networks, the composition of your provider networks, and the overlap across networks.

4. How does the provider recruitment process vary between your Marketplace networks and Medicaid/CHIP networks?
5. Do you face any particular challenges with recruiting for either network? If so, what types of challenges?
6. What reasons do you hear from providers for not wanting to participate in your Marketplace networks? In your Medicaid/CHIP networks?
7. What differences are there between your state's Marketplace network adequacy standards and the network adequacy standards for Medicaid/CHIP? How do these differences affect the composition of your networks?
8. What differences are there between monitoring and assessing Marketplace network adequacy in your state and monitoring and assessing Medicaid/CHIP network adequacy?
9. Do the requirements for contracting with safety net providers or essential community providers differ between the Marketplace and Medicaid/CHIP? If so, what are the differences?
10. When you were constructing the provider network for your Marketplace plans, how important was it that there would be overlap between the Marketplace and Medicaid/CHIP networks? Was any particular effort made to see that the networks for the different programs would be similar?
11. How is it determined which providers participate in which lines of business? Do providers have the option to participate in some lines of business and not in others?
12. Are you considering undertaking any efforts to encourage providers to participate across multiple lines of business? What types of efforts might be considered?
13. As mentioned previously, we looked at the degree of overlap for just primary care providers in **market area**. Do you review your networks overall for provider overlap? If so, does our

characterization seem accurate? Do the overlap patterns vary by specialty type, or geographic area?

IV. Transitions and Continuity of Care

In this series of questions, we want to understand what happens when members move from one program to another and related issues regarding continuity of care.

14. If an individual who was enrolled in one of your Marketplace plans is determined to be eligible for Medicaid/CHIP, please walk me through the steps that occur when someone needs to enroll in a Medicaid/CHIP plan. If you have not experienced any transitions yet, please feel free to comment on how you expect that the process will work.
 - i. What information are you required to share, and with whom?
 - ii. How are the systems set-up to handle these transitions? Do you offer any customer assistance?
 - iii. Have you found any issues at the point of transition?
 - iv. Do you undertake any steps to encourage members to stay with the same managed care organization or primary care provider?
15. How does the reverse process work (moving from Medicaid/CHIP to Marketplace plans)? Have you found any issues with this process?
16. **[If California issuer]** Are any of the plans offered by your company “bridge” plans (Marketplace plans that have enrollment limited to consumers transitioning from Medicaid/CHIP coverage to Marketplace coverage, or family members of consumers enrolled in or transitioning from Medicaid/CHIP coverage)? Was this option considered? Why or why not?
17. How do policies for reimbursing out-of-network services differ for Marketplace and Medicaid/CHIP plans (if they differ at all)?

V. Wrap-Up and Lessons Learned

I have just a few more overarching questions for you.

18. Do you see any particular advantages to participating in both the Marketplace and Medicaid/CHIP? If so, what are they?
19. Do you see any particular disadvantages to participating in both programs?
20. If you could offer any suggestions for improving the Marketplace or Medicaid/CHIP program in **State**, what would they be?

Is there anything else you’d like to add to our conversation? Thank you very much for your time.

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REFERENCE LIST

- Alliance for Advancing NonProfit Health Care. “Basic Facts and Figures: Nonprofit Health Plans.” 2012. Available at [<http://www.nonprofithealthcare.com/resources/BasicFactsAndFigures-NonprofitHealthPlans9.9.08.pdf>].
- American Association of Health Plans. “AAHP/Dorland Directory of Health Care Plans.” Philadelphia, PA: Dorland Healthcare Information, 2000.
- Arizona Administrative Code. AAC R20-6-201. Available at [http://www.azsos.gov/public_services/Title_20/20-06.htm#ARTICLE_2].
- Arizona Health Care Cost Containment System. “AHCCCS Contractor Operations Manual.” September 12, 2012. Available at [<http://www.azahcccs.gov/shared/Downloads/ACOM/ACOM.pdf>].
- Atlantic Information Services, Inc. “AIS’s Directory of Health Plans: 2013.” Washington, DC: Atlantic Information Services, Inc., 2013.
- Bachrach, Deborah, Patricia Boozang, and Allison Garcimonde. “Medicaid Managed Care: How States’ Experience Can Inform Exchange Qualified Health Plan Standards.” Manatt Health Solutions. Prepared for the Centers for Health Care Strategies, Inc.. 2011. Available at [http://www.statecoverage.org/files/CHCS_Medicaid_Managed_Care_and_QHP_Standards_final.pdf].
- Bauman, Noam, Erica Coe, Jessica Ogden, Ashish Parikh. “Hospital Networks: Updated National View of Configurations on the Exchanges.” McKinsey & Company for the Center for U.S. Health System Reform, June 2014. Available at [<http://healthcare.mckinsey.com/hospital-networks-updated-national-view-configurations-exchanges>].
- California Code of Regulations. 22 CCR 53880. Available at [<http://www.cdss.ca.gov/shd/res/pdf/53800.pdf>].
- California Department of Health Care Services. “Marketing Requirements for Medi-Cal and Covered California.” October 30, 2013. Available at [<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-015.pdf>].
- California Legislative Information. “SBX1-3 Health Care Coverage: Bridge Plan.” 2013. Available at [http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320141SB3].
- Center for Consumer Information & Insurance Oversight. “New Loan Program Helps Create Customer-Driven Non-Profit Health Insurers.” January 1, 2014a. Available at [<http://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html>].

Center for Consumer Information & Insurance Oversight. “Casework Guidance for Issuers in Federally-facilitated Marketplace, including State Partnership Marketplaces.” March 13, 2014b. Available at [<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/casework-guidance-03132014.pdf>].

Center for Consumer Information & Insurance Oversight. “Letter to Issuers on Federally Facilitated and State Partnership Exchanges.” April 5, 2013. Available at [https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf].

Centers for Medicare and Medicaid Services. “Continuous Eligibility for Medicaid and CHIP Coverage.” Available at [<http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Outreach-and-Enrollment/Continuous.html>]. Accessed August 2014a.

Centers for Medicare and Medicaid Services. “State Medicaid and CHIP Income Eligibility Standards.” Available at [<http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf>]. Accessed August 2014b.

Centers for Medicare and Medicaid Services. “Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid.” December 10, 2012. Available at [<http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf>].

Christakis, Dimitri, Loren Mell, Thomas Koepsell, Frederick Zimmerman, and Frederick Connell. “Association of Lower Continuity of Care with Greater Risk of Emergency Department Use and Hospitalization in Children.” *Pediatrics*, vol. 103, no. 3, March 2001, pp. 524–529.

Code of Federal Regulations. 42 CFR 300gg-1. Available at [<http://www.law.cornell.edu/uscode/text/42/300gg-1>].

Code of Federal Regulations. 42 CFR 438.104. Available at [<http://www.gpo.gov/fdsys/pkg/CFR-2009-title42-vol4/pdf/CFR-2009-title42-vol4-sec438-104.pdf>].

Code of Federal Regulations. 42 CFR 457.90. Available at [<http://www.law.cornell.edu/cfr/text/42/457.90>].

Code of Federal Regulations. 45 CFR 156.225. Available at [<http://www.law.cornell.edu/cfr/text/45/156.225>].

Code of Federal Regulations. 45 CFR 156.230. Available at [<http://www.law.cornell.edu/cfr/text/45/156.230>].

Code of Maryland Regulations. “Marketing.” COMAR 10.09.65.23. Available at [<http://www.dsd.state.md.us/comar/getfile.aspx?file=10.09.65.23.htm>].

Covered California. “Qualified Health Plan Issuer Marketing Guidelines.” September 12, 2013. Available at [<http://board.coveredca.com/meetings/2013/09%20Sep%20Meeting%20Materials/PDFs/QHP%20Issuer%20Marketing%20Guidelines.pdf>].

Dash, Sarah, Kevin Lucia, Katie Keith, and Christine Monahan. “Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges.” The Commonwealth Fund, July 2013. Available at [http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Jul/1696_Dash_key_design_decisions_state_based_exchanges.pdf].

Gill, James M., and Arch G. Mainous III. “The Role of Provider Continuity in Preventing Hospitalizations.” *Archives of Family Medicine*, vol. 7, July/August 1998, pp. 352–357.

Health Resources and Services Administration, U.S. Department of Health and Human Services. “340B Drug Pricing Program.” Available at [<http://www.hrsa.gov/opa/>]. Accessed October 20, 2014.

Hoag, S., A. Swinburn, S. Orzol, M. Barna, M. Colby, B. Natzke, C. Trenholm, F. Blavin, G.M. Kenney, M. Huntress, J. Edwards, E. Ellis, R. Kellenberg, D. Rodin, S. Silow-Carroll, B. Courtot, I. Hill, M. Wilkinson, S. Dorn, and S. Benatar. “CHIPRA-Mandated Evaluation of Express Lane Eligibility: Final Findings.” Princeton, NJ: Mathematica Policy Research, December 2013.

Illinois Department of Healthcare and Family Services. “Contract For Furnishing Health Services by a Managed Care Organization. Final model.” 2014. Available at [<http://www2.illinois.gov/hfs/ManagedCare/Documents/mco.pdf>].

Illinois Department of Insurance. “Illinois Qualified Health Plan Application Guidelines.” March 29, 2013. Available at [<http://insurance.illinois.gov/cb/2013/CB2013-06.pdf>].

Illinois Division of Insurance. “Review Requirements Checklist.” For Policies issued after 01/01/2014. Available at [http://insurance.illinois.gov/LAH_HMO_IS3_Checklists/documents/Health%20Premium%20Rate%20Review%20Checklist.pdf].

Kaiser Family Foundation. “Status of State Action on the Medicaid Expansion Decision, 2014.” 2014. Available at [<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>].

Kentucky Administrative Regulations. 806 KAR 12:010. Available at [<http://www.lrc.state.ky.us/kar/806/012/010.htm>].

Kentucky Administrative Regulations. 900 KAR 10:010E. Available at [<http://healthbenefitexchange.ky.gov/Documents/907%20KAR%2010%20010%20E%20Certificate%20of%20QHP%20as%20filed.pdf>].

Kentucky Administrative Regulations. 907 KAR 17:010. Available at [<http://www.lrc.state.ky.us/kar/907/017/010.htm>].

- Kentucky Cabinet for Health and Family Services, Department for Medicaid Services, Commonwealth of Kentucky. “Strategy for Assessing and Improving the Quality of Managed Care Services.” 2011. Available at [<http://chfs.ky.gov/NR/rdonlyres/B59F657F-EEDE-4120-9D50-8251F255718E/0/QualityofManagedCareServicesDraft60911workingcopyld3165.pdf>].
- Maryland Health Benefit Exchange. “Maryland Health Connection Carrier Reference Manual.” Release 2.0. June 2013. Available at [http://marylandhbe.com/wp-content/uploads/2013/06/MHBE_CarrierManual_060413.pdf].
- McCarty, Sally and Max Farris. “Charting the Road to Coverage.” State Health Reform Assistance Network, August 2013. Available at [http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407486].
- McKinsey Center for U.S. Health System Reform. “Hospital Networks: Updated National View of Configurations on the Exchanges.” June 2014. Available at [http://healthcare.mckinsey.com/sites/default/files/McK%20Reform%20Center%20-%20Hospital%20networks%20national%20update%20%28June%202014%29_0.pdf].
- National Conference of State Legislatures. “Healthcare Reform: Affordable Care Act Legislative Database.” August 11, 2014. Available at [<http://www.ncsl.org/research/health/new-health-reform-database.aspx>].
- National Conference of State Legislatures. “Managed Care State Laws.” Updated September 2011. Available at [<http://www.ncsl.org/research/health/managed-care-state-laws.aspx>].
- New York State Department of Health. “Medicaid Managed Care and Family Health Plus Model Contract.” March 1, 2011. Available at [http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_and_family_health_plus_model_contract.pdf].
- New York State of Health. “QHP and Dental Plan Model Agreement with NYSOH.” January 31, 2013. Available at [<http://info.nystateofhealth.ny.gov/sites/default/files/QHP%20and%20Dental%20Plan%20Model%20Agreement%20with%20NYSOH.pdf>].
- Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. “Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period.” May 1, 2014. Available at [http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf].
- Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. “Medicaid and CHIP Risk-Based Managed Care in 20 States Experiences over the Past Decade and Lessons for the Future. Final Report.” Washington, DC: ASPE, July 2012. Appendix Table 6: Provider Network/Access Contractual Requirements in Study States, 2010.
- Office of the New York Health Benefit Exchange. “Invitation to Participate in the New York Health Benefit Exchange.” New York State Department of Health, January 31, 2013.

- Orfield, Cara, Lauren Hula, and Michael Barna. “Transitions Across the Marketplace, Medicaid, and CHIP: How Similar are Primary Care Physician Networks Across Programs?” Final report submitted to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Ann Arbor, MI: Mathematica Policy Research, November 3, 2014.
- Rosenbaum, Sara, Nancy Lopez, Devi Mehta, Mark Dorley, Taylor Burke, and Alicia Widge. “Realizing Health Reform’s Potential: How Are State Insurance Marketplaces Shaping Health Plan Design?” The Commonwealth Fund, December 2013.
- Silver State Health Insurance Exchange. “Medicaid Managed Care Organization (MCO) Transition Plans.” June 12, 2013. Available at [http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Meetings/13-Medicaid_MCO_Transition_Plans.pdf].
- Sommers, Benjamin, John Graves, Katherine Swartz, and Sara Rosenbaum. “Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options Can Ease Impact.” *Health Affairs*, vol. 33, no. 4, April 2014.
- State of Arizona. “Application Requirements for Qualified Health Plan Certification.” Version 7.0, January 3, 2012. Available at [http://www.azinsurance.gov/publications/AZ_Exchange_Requirements_v7_1-3-12_final.pdf].
- U.S. Congress. “Patient Protection and Affordable Care Act.” Pub. Law 111-148. 124 Stat No. 119–124. March 23, 2010. Government Publications Office website. Available at [<http://docs.house.gov/energycommerce/ppacacon.pdf>].
- van Walraven, Carl, Natalie Oake, Alison Jennings, and Alan Forster. “The Association Between Continuity of Care and Outcomes: A Systematic and Critical Review.” *Journal of Evaluation in Clinical Practice*, vol. 16, 2010, pp. 947–956.

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