



Family Medicine Principles for State Health Insurance Exchanges

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A key component of the *Patient Protection and Affordable Care Act* (ACA) is the opportunity for states to establish health insurance exchanges, or marketplaces. Exchanges provide a forum for individuals and small businesses to compare and purchase private health insurance plans. ACA requires the U.S. Department of Health and Human Services to establish initial guidance on the formation of the exchanges and what basic components a product must have to qualify for this new marketplace. However, states retain a great degree of flexibility in how exchanges operate, what benefits products can or should include beyond the federal floor, and how patients and physicians interact with insurers and their products within the exchanges. A patient will select a plan, be rated for a plan's premium by the insurer based on limited criteria, and have eligibility for premium credits (a subsidy) determined.¹

In weighing options to form exchanges, states should adopt policies to protect consumers, improve quality of care provided, and decrease costs across the health care system. A critical element to achieving such goals is primary care. Studies repeatedly demonstrate that a primary care-based system restrains cost increases, improves quality and increases patient satisfaction.²

To ensure exchanges utilize all primary care has to offer, family physicians encourage states to consider the following principles in developing exchanges:

- 1) FAIR REPRESENTATION OF STAKEHOLDERS: The governing body of an exchange should include, by statute, at least one seat for consumers and at least one for primary care physicians, in at least equal proportion to the total number of seats allotted to insurers, specialty medicine, health systems and other stakeholders.**

Section 1311(d)(6) of ACA requires exchanges to consult with a broad range of stakeholders. Exchange governing boards need to comply with federal and state law, but because ACA provides few requirements related to governance, states can mold them as they see fit.³ A board of directors should be appointed based on relevant expertise, representing a broad spectrum of interests.⁴

- 2) PAYMENT FOR THE PATIENT-CENTERED MEDICAL HOME (PCMH) & ENHANCED ACCESS: Benefit design should incentivize primary care. Enhanced payment for PCMHs, care coordination, and enhanced access through e-visits, open scheduling and expanded hours should be considered as part of "qualified coverage" for plans wishing to participate.**

With new medical-loss ratio requirements and the likelihood of increased competition, insurers participating in exchanges will need to limit costs and encourage savings. Under section 1301, ACA allows qualified health plans to offer coverage through a primary care medical home, also known as a patient-centered medical home, a delivery model that is proven to reduce the frequency and length of emergency room visits and hospitalizations,⁵ restrain cost increases, and enhance the quality of care provided, particularly for those with chronic conditions.⁶

- 3) STANDARDIZED CONTRACTING: Physician contracting should be standardized across all plans in any exchanges, just as enrollee applications are standardized. States opting to create multi-state exchanges, or enter into interstate compacts for the purchase of insurance, should harmonize contracting rules across all participating states. "All products clauses" must be prohibited.**

States can regulate the market inside an exchange in the same way they can regulate health plans provided outside.⁷ Various states already prohibit "all products clauses," fine-print contractual language

requiring physicians who accept one health insurance product to accept all health insurance products from that carrier.⁸

4) SET PRIMARY CARE TARGETS: Exchanges should set targets for primary care spending by participating plans.

Rhode Island successfully implemented this strategy to temper the increase of premiums and other costs in the private market, while promoting a more efficient, PCMH- and primary care-oriented delivery system.⁹

5) REQUIRE ROBUST PRIMARY CARE-BASED ESSENTIAL BENEFITS: States should require health plans to offer primary care services beyond those required by the federal essential benefits regulation.

ACA requires the federal government to set a floor for “essential benefits” every plan in an exchange must offer. States should ensure that essential benefits packages include important front-end investments in patient health, including, but not limited to, no co-pay for out-of-network primary care services, low or no cost medications for patients with certain chronic diseases (asthma, for example) and incentives for patient engagement.

6) PRESUME ELIGIBILITY: Enrollees should receive presumptive eligibility—or provisional enrollment—to allow for delivery of essential preventive and primary care services upon submission of an application.

Not only do disruptions in insurance coverage have adverse effects on access to care and administrative costs, problems can arise simply from changes in health plans, even without gaps in coverage.¹⁰ ACA expands presumptive eligibility for Medicaid applicants and first-dollar coverage of preventive services. Combining presumptive eligibility for all plans, public and private, with the new first-dollar coverage for preventive services delivered by primary care physicians will help keep patients out of emergency rooms while controlling costs. States should enact policies to simplify patients’ transitions between plans through policies that reduce administrative burdens, such as portability of prescriptions and prior authorizations.

7) REWARD QUALITY: Quality measures should be aligned across plans in the exchange(s) and with the state’s Medicaid, CHIP and state and local employee health benefits plans. Such measures also should coordinate with Medicare, when possible.

Reporting to multiple payers on different measures creates an undue administrative burden on physician practices. ACA encourages exchange plans to create market incentives for quality improvement to coordinate care and reduce the use of unnecessary care. If the exchange requires physicians and plans to spend significant resources on initiatives not required of non-exchange plans, exchange plans could seem less competitive and increase the already substantial reporting burden on physicians.¹¹

8) PROTECT CONSUMERS & PHYSICIANS: Consumer assistance and information offices, if not incorporated into the administrative framework of the exchange(s), should work closely with the state’s exchange(s). Patients and physician practices ought to be allowed to access the services of such programs for concerns about insurance products purchased both inside and outside the exchange.

Exchange navigators and consumer assistance offices will provide fair and impartial, culturally- and linguistically-appropriate information concerning enrollment in qualified health plans and available subsidies through the exchange, facilitate enrollment in qualified health plans, and provide referrals for complaints.¹²

For additional information on the value of primary care, please visit our web site, aafp.org, contact the Academy of Family Physicians [in your state](#), or contact the AAFP Government Relations office at capitol@aafp.org.

SOURCES

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