NATIONAL PHYSICIANS ALLIANCE

Policy Statement in Support of Robust State-Level Health Insurance Exchanges
August, 2011

The National Physicians Alliance offers its strong support for the implementation of robust, state-level health insurance exchanges during implementation of the Patient Protection and Affordable Care Act. The NPA believes all Americans should have access to affordable, high-quality health care.
We recognize that health insurance exchanges at the state level are one of the PPACA's main vehicles for expanding access to health insurance and necessary primary care. They will provide a new, competitive marketplace for previously uninsured individuals and employees of small businesses to obtain health insurance. Indeed, the exchanges provide a lever and an opportunity to achieve a more patient-centered, efficient health care system. These new health marketplaces will provide the necessary incentives and generate the needed tools to ensure better health outcomes at lower costs for individuals, families, businesses, and society.

The NPA offers the following **principles** for robust state health insurance exchanges:

1. Exchanges should be **active purchasers of health care**, using their capabilities to decrease administrative costs, incentivize high-quality health care, maximize enrollment, increase transparency, and bend the cost curve. Only those plans that offer enhanced value, quality, affordability, and consumer protection should be offered. This will lead to better health outcomes, reduced health care costs, and protection of taxpayers who are subsidizing the exchanges.

2. Exchanges should improve consumer empowerment in their health care decisions by offering multiple, user-friendly ways for newly insured Americans to make **"apples to apples" comparisons** about health care plans based on accessible, **clear information about cost, coverage, and quality**. Exchanges also should promote consumer empowerment by assuring **substantial representation of consumers/citizens** on the exchange governing board. The board should reflect the racial and ethnic, gender, and geographical distribution of those served.

3. Exchanges should provide **culturally and linguistically appropriate** outreach and enrollment materials.

4. Exchanges should provide **adequate choices of health plans and health care professionals** in all regions of their states. Exchanges should be encouraged to foster the development and growth of new plans, such as **state-based public options and not-for-profit cooperatives**, to increase the number and quality of choices for consumers.

5. The exchanges should **coordinate outreach and enrollment with existing public programs** to ensure that exchange enrollees eligible for federal tax credits and cost-sharing reductions enroll and maintain their coverage, and also to **ensure seamless coverage and continuity of care** as people move between public programs and exchange coverage.

6. Exchanges should use whatever policy tools are necessary to **guard against adverse selection.**

7. Governance and oversight of exchanges should be as **open and transparent** as possible, and meetings always should provide opportunities for input by health care experts and the public. The meetings should be held in public using "open meetings" concepts including advanced notice and publication of agendas, minutes, etc. **Exchanges should include physician representation, including at least equal representation of primary care and specialist physicians. Health industry stakeholders** (e.g., health professionals, hospitals, health insurers) **should be in total a minority on the board**. **Conflicts of interest should be minimized** whenever possible and board members should **fully disclose** their affiliations and interests.

The next steps, then, are to ensure that the participating health plans in the exchanges provide access to high-quality, affordable, patient-centered care. To achieve this goal while simultaneously reducing health care disparities and costs, the following issues must be addressed:

1. **Participating health plans in health care exchanges must emphasize primary care and everyone insured in the exchanges should have access to a medical home.**

   Numerous studies (1) document that increased access to primary care improves health care quality and reduces health care costs. The Patient-Centered Medical Home (PCMH) is a new model of care endorsed by major primary care medical societies and increasingly by innovative health care payers as a way to achieve these goals.(2) The traits of a PCMH include:
   a. Continuity of care provided by a health care professional who takes responsibility for ongoing care of their patients including acute care, chronic care, and preventive care.
   b. Easy access for appointments.
   c. Utilization of the latest health information technology to access medical research, maintain electronic health records, and provide the highest quality of care.
   d. Team-based approaches that ensure better coordination of care between primary care and specialist providers, as well as in transitions of care (e.g., from hospital discharge to home or nursing home).
   e. Continuous quality improvement.

2. **Payment reform that rewards quality of care over volume of services will help achieve the improved health care outcomes that we all desire.** Numerous partnerships and pilot programs around the country are beginning to demonstrate the improved quality and lower costs associated with payment reforms (3) such as "blended payment" (which includes a fee-for-service component, a per-member-per-month care management fee, and a performance/quality bonus) and accountable care organizations (ACO's).(4) Various states around the country are bringing

together payers with government and health care providers to develop and facilitate these new models.

3. **Patients and citizens should be empowered to choose health plans that provide data about the quality of care that they provide.** Exchanges will play a pivotal role in facilitating an understandable and reliable set of quality data to 21st century health care consumers. If the data is accessible to patients and payers (employers and government), it will incentivize physicians, hospitals, and health plans to provide the best care possible.

4. **Health plans in the exchanges should assist health care professionals and their practices with health information exchange and increased use of electronic health records.** Communities that invest in this exchange can facilitate better care and reduced duplication of tests or conflicting prescriptions when a patient goes to the emergency room or is admitted to the hospital. This will yield more robust data sets that can be utilized for quality improvement.

5. **Exchanges can facilitate improved stewardship of health care resources.** The NPA and other health organizations are demonstrating that improved electronic records, care coordination, and continuing education can lower costs by reducing duplication of testing and other services. The NPA believes that physicians should be pressured to disclose and rewarded for eliminating any financial conflicts of interest when it comes to prescribing medications, ordering tests, or conducting procedures.

6. **The health care workforce must be bolstered with increased numbers of primary care physicians.** Numerous studies document the shortage of primary care physicians in the United States (6), a shortage that is fueled in part by significant medical school debt and payment disparities with other specialties. In addition to providing increased avenues for insurance, states and their exchanges should encourage increased numbers of primary care physicians through loan forgiveness programs and efforts to bolster primary care physicians' compensation.

References:

1. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Quarterly. 2005. 83(3): 457-502.
2. See the Patient-Centered Primary Care Collaborative at www.pcpcc.net
3. Antos J, Bertko J, Chernew M, et al. Bending the cost curve through health reform implementation. The Brookings Institution. 2010. Accessed March 20, 2011, at http://www.brookings.edu/reports/2010/10_btc_II.aspx .
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6. Iglehart J. Reform and the health care workforce – current capacity, future demand. October 21, 2009. (Accessed March 15, 2011, at http://healthpolicyandreform.nejm.org/?p=2129).