

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-09

Subject: Health Insurance Exchange Authority and Operation

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Referred to: Reference Committee J
(William J. Holt, MD, Chair)

1 Leading health system reform proposals have called for the establishment of a health insurance
2 exchange to serve as a managed marketplace on the state, regional and/or national level for the
3 purchase of health insurance. Support for creating a health insurance exchange has been based
4 partly on the success of the Massachusetts health reform effort, which resulted in a 2.6%
5 uninsurance rate as of summer 2008. As the American Medical Association (AMA) continues to
6 advocate for mechanisms to cover the uninsured, it has been essential to monitor the development
7 and implementation of the authority and responsibilities delegated to proposed health insurance
8 exchanges to ensure optimal patient choice in health plans and the protection of the physician-
9 patient relationship.

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11 The entity or entities operating a health insurance exchange could have several potential roles.
12 Many possible functions that have been proposed are based on what the Commonwealth Health
13 Insurance Connector Authority carries out in Massachusetts, as well as the current responsibilities
14 of the Federal Employee Health Benefits Plan (FEHBP). The roles of the entity operating an
15 exchange could also be greater in the context of implementing an individual mandate.

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17 In particular, there are key issues associated with health insurance exchanges that merit further
18 consideration, especially given long-standing AMA policy conceptually supportive of exchanges.
19 This report describes potential regulatory authority to be delegated to the executive branch related
20 to health insurance exchange organization, potential federal benefit standards, and the possible
21 participation of a public or non-profit plan option within any exchange. The report also outlines
22 other issues associated with health insurance exchange implementation, summarizes relevant AMA
23 policy and advocacy, and presents policy recommendations.

24 25 THE IMPACT OF HEALTH INSURANCE EXCHANGE ORGANIZATION

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27 Stakeholders involved in the debate surrounding the creation of a health insurance exchange have
28 proposed different models of organization. The two leading approaches have been to create a
29 national exchange or to create exchanges in every state. Proposals have also included options to
30 create regional exchanges or subsidiary exchanges within a state.

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32 The responsibilities delegated to the executive branch with respect to exchange operation differ
33 between the national exchange and state exchange approaches. In the context of a national
34 exchange, it would be likely that the executive branch would be granted the authority to establish
35 and operate the health insurance exchange, including issuing and accepting bids and negotiating
36 contracts for plans, certifying plans, implementing a risk-pooling mechanism, facilitating outreach
37 and enrollment, determining the size of employers that can participate in the exchange, and

1 specifying benefits to be made available under plans. If regional, state and subsidiary exchanges
2 are created instead of a national exchange, legislation and regulations would likely outline criteria
3 for exchanges, and states then would submit proposals for state and regional exchanges to be
4 certified by the federal government. The federal government could also supply start-up financial
5 assistance, provide technical assistance and develop a module for plan information to be used by all
6 states.

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8 A requirement that individuals have health insurance coverage would also impact the authority
9 granted to entities administering federal and state health insurance exchanges. For example, an
10 individual mandate would likely require individuals to have coverage that meets a standard for
11 health insurance coverage that would be deemed acceptable to meet the individual mandate and not
12 be assessed any financial penalty. If financial assistance is provided to eligible individuals and
13 families to purchase health insurance coverage through the exchange in order to meet the mandate,
14 the locus of control for administering this assistance would likely be federal for a national
15 exchange and state-based for state exchanges.

16 17 THE IMPACT OF FEDERAL BENEFITS STANDARDS

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19 In anticipation of health system reform legislation that creates a minimum benefits package
20 individuals would be required to have, the Council on Medical Service presented Report 7-A-07,
21 which established principles to evaluate the adequacy of health insurance coverage options (Policy
22 H-165.846, AMA Policy Database). Proposals for a federally-mandated basic benefits package
23 would likely serve as a foundation to set minimum benefits standards for qualified plans operating
24 in federal, regional or state exchanges; develop criteria related to the minimum benefit standards of
25 plans that individuals and families eligible for financial assistance (i.e., premium and cost-sharing
26 credits) could access; and determine minimum creditable coverage related to the individual
27 mandate. A benefits requirement could also be extended to plans operating outside of the exchange
28 environment. Such proposals have envisioned the Secretary of HHS having the authority to adopt
29 and update benefits standards for qualified plans in the exchange, including covered treatments,
30 items and services, and cost-sharing levels.

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32 These minimum benefit standards would also likely lead to regulations addressing the coverage of
33 physician services within the exchange. Once the essential benefits package is determined,
34 regulations would likely be promulgated that address the type, scope, frequency and duration of
35 physician services that must be covered by qualified health plans. Regulations would likely also be
36 issued that address which providers are eligible to be paid for providing certain services, which has
37 the ability to emerge as a scope of practice issue. Finally, regulations would likely guide the
38 determination of patient eligibility for certain services.

39 40 THE IMPACT OF A PUBLIC OR NON-PROFIT OPTION

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42 One of the most controversial aspects surrounding the creation and operation of a health insurance
43 exchange is the establishment of a public or non-profit health insurance option that some proposals
44 have suggested be offered through the exchange to compete against the participating private plans.
45 While some proposals have called for the public plan to offer only a basic benefits package, others
46 have called for the public plan to offer various tiers of benefit levels. Most proposals would
47 require the public health insurance option to meet the same requirements as private plans regarding
48 consumer protections, provider networks, benefit levels and cost-sharing. Proposals have also
49 differed as to whether the public plan would be required to be self-sustaining, not dependent on the
50 federal treasury and meet a federal solvency standard.

1 Some proposals would require physicians who participate in Medicare to also participate in the
 2 public health insurance option. Additional proposals would require physicians participating in
 3 Medicare to opt out of participating in the public health insurance option if they do not wish to
 4 participate, while others would not require physicians to proactively opt out of participating in the
 5 public plan option. Another key issue for physicians has been physician payment under the public
 6 health insurance option. Whereas some proposals have called for physician payment to somehow
 7 be linked to Medicare, other prominent proposals have included provisions to make physician
 8 payment within the public plan option negotiated like private plans.

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 10 Establishing “co-op” plans emerged as a leading alternative to creating a truly public health
 11 insurance option to participate in the exchange. The notion of consumer cooperatives, initially
 12 proposed by Senator Kent Conrad (D-ND), would create a non-profit, non-government, consumer-
 13 driven insurance option in every state. These cooperatives would be offered as an option through
 14 the exchange and would be subject to all exchange rules. A consumer cooperative would function
 15 very much like a traditional cooperative, in that it would be democratically controlled by its
 16 members and governed by an elected board. Any surpluses from its operation would be returned to
 17 its members or reinvested, potentially in the form of lower premiums, lower cost-sharing or
 18 expanded benefits. Consumer cooperatives would receive start-up funds and would be expected to
 19 be self-sustaining after the start-up period. Cooperatives could also operate on a regional or
 20 national level.

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 22 The authority granted to the Executive Branch would differ based on whether a public or non-profit
 23 plan option would participate in an exchange. Should a public plan be established to compete with
 24 private plans within an exchange, the Secretary of HHS would likely have a role in the
 25 administration of the public health insurance option. These responsibilities could include
 26 negotiating premiums and reimbursement rates and developing conditions of participation. As
 27 standards for premiums and reimbursement rates will likely be updated for each plan year, this
 28 could affect both patient enrollment and physician participation in the program.

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 30 **OTHER HEALTH INSURANCE EXCHANGE IMPLEMENTATION ISSUES**

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 32 The Council would be concerned with any authority granted to the Executive Branch that could
 33 usurp the role of state insurance commissioners in the arenas of oversight and enforcement of the
 34 operation of health insurance exchanges and the health plans participating therein. Specifically, the
 35 Council believes that state insurance commissioners have a vital regulatory role ensuring consumer
 36 protections such as grievance procedures, external review, oversight of agent practices and training,
 37 and market conduct. Of concern and importance to physicians is the regulatory role of state
 38 insurance commissioners in physician protections including state prompt pay laws, protections
 39 against health plan insolvency, and fair marketing practices.

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 41 The Council notes that additional responsibilities may be delegated to the Executive Branch, such
 42 as establishing standards to ensure health benefit plan transparency with regard to health care
 43 provider reimbursement arrangements. The Executive Branch could also have the responsibility to
 44 establish criteria for qualified health plans addressing claims payment policies and practices;
 45 periodic financial disclosure; data on enrollment, disenrollment, number of claims denials, and
 46 rating practices; and information on cost-sharing and payment regarding out-of-network coverage.

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 48 For qualified health plans sold in state or national exchanges, it is also likely that the Secretary of
 49 HHS would have the responsibility to promulgate regulations that address marketing and network
 50 adequacy. These regulations will be vital in ensuring that patients have a wide choice of physicians
 51 and health plans, regardless of their health status.

1 LEGISLATIVE ACTIVITY

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The Council conceived this self-initiated report at its January 2009 meeting, and preparing the report during the rapid and fluid legislative activity of summer 2009 has been a challenge. At the time this report was written, three pieces of comprehensive health system reform legislation had been proposed. All three of these proposals contained provisions for the establishment of exchanges, but differed in their approaches.

9 H.R. 3200, the America’s Affordable Health Choices Act of 2009, developed jointly by the three committees with jurisdiction in the House of Representatives (House Energy and Commerce Committee, House Ways and Means Committee, House Education and Labor Committee), has been the prominent piece of legislation in the House of Representatives. At the time this report was written, a vote on the House of Representatives’ legislation was expected in the fall of 2009. The Senate Health, Education, Labor and Pensions (HELP) Committee approved its bill, the “Affordable Health Choices Act,” in July of 2009. At the time this report was finalized in September 2009, Senate Finance Committee Chairman Max Baucus had released his mark “America’s Healthy Future Act of 2009.” The final Senate product will be an amalgamation of the bills of the Senate HELP and Finance Committees. A vote on the Senate floor of this amalgamated legislation was also expected in the fall of 2009.

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RELEVANT AMA POLICY AND ADVOCACY

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AMA policy is supportive of the general concept of creating a health insurance exchange. Policy H-165.846 (AMA Policy Database) advocates principles to guide the evaluation of adequacy of health insurance options, including the principles that any health insurance exchange must include a wide variety of coverage options from which to choose, and that existing federal guidelines regarding types of insurance coverage should be used as benchmarks of meaningful coverage. Numerous AMA policies support the FEHBP as a model for health system reform based on competition among health plans and choice for patients (Policies H-165.855[1], H-165.856, H-165.995[3], H-165.845[2], and H-330.898[6]). The AMA also advocates the formation of small employer and other voluntary choice cooperatives (Policy H-165.882). Policy H-165.862 endorses the concept and use of Internet-based health insurance marts and health benefits systems as mechanisms for employers and individuals to select and purchase health insurance. AMA policy opposes an expansion of the Medicare program and instead advocates for reforms to strengthen the program in the short-term and its eventual replacement with a self-funded, private-sector approach to financing health care for the elderly, with equitable means testing provisions (H-165.985, H-330.898, H-330.896). The AMA House of Delegates discussed the public plan option at the 2009 Annual Meeting and adopted Policy H-165.888[4], which supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

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AMA policy underscores that coverage expansions and the creation of an exchange must be consistent with the broad goals of market regulation. Policy H-165.856 contains a set of principles to guide health insurance market regulation, including greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan; replacing strict community rating with modified community rating; replacing guaranteed issue regulations with guaranteed renewability; and removing legislative and regulatory barriers to the formation and operation of group purchasing alliances, and to the development of multi-year insurance contracts. Policies H-165.920[11] and H-165.995 support the use of state high-risk pools. AMA policy also supports minimizing benefit mandates unrelated to patient protections in order to expand individual choice

1 and allow market experimentation to find the most attractive combinations of plan benefits and
2 cost-sharing features (Policies H-165.856[9b], H-180.978, H-165.997, and H-165.882[2]).

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4 The AMA has been an active participant in health reform discussions with the Obama
5 Administration and key authorizing committees in the House and Senate. The AMA submitted its
6 comments in response to the Senate Finance Committee's policy options document addressing
7 coverage (which included alternatives for the inclusion of a public plan option), the House Tri-
8 Committee draft health care reform proposal, and the Senate HELP Committee's "Affordable
9 Health Choices Act" draft health care reform proposal. The AMA also submitted a statement for
10 the record to the House Ways and Means Committee regarding insurance market reforms as part of
11 overall health system reform.

12 13 DISCUSSION

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15 The Council believes the AMA has an adequate policy foundation from which to participate in
16 discussions and negotiations regarding the establishment of an exchange and the inclusion of a
17 public or non-profit plan option. However, the Council notes that many aspects and specifics of
18 health insurance exchange operation and implementation, including the standards for private and
19 public/non-profit entities operating therein, will be determined in the regulatory process.

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21 Ultimately, the Council believes that the success of health insurance exchanges not only depends
22 on the number of individuals and families becoming insured through these mechanisms, but the
23 degree of choice of health plans afforded to individuals and families within them. The Council
24 believes that during the regulatory process, the health plan choices to be offered through any
25 exchange should not be further limited so patients have the ability to purchase the coverage that
26 best suits their needs, in accordance with Policy H-373.998[2]. This would entail not only a
27 diversity in the benefits packages available, but also health plans with varying levels of cost-
28 sharing.

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30 Within any exchange, the Council believes it will be essential for patients to be provided with
31 standardized and easy-to-understand information to be able to compare the health insurance options
32 in the exchange based on cost, level of coverage and other factors. Accordingly, health plans need
33 to provide necessary information to patients and the entity operating an exchange, including clear
34 and accurate explanations of covered services, cost-sharing obligations, out-of-pocket limits and
35 lifetime benefit caps, and excluded services. Existing AMA policy on health insurer conduct
36 applies to all plans, whether or not they participate in an exchange. In an exchange environment,
37 the Council finds it especially critical that AMA policy be followed addressing health plan
38 transparency in interactions with both physicians and patients, and supporting physician freedom of
39 practice (Policies H-185.975, H-165.846[4], H-385.926).

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41 It will be imperative that any entity or entities tasked with operating an exchange implement
42 transparent processes. The regulatory authority granted to these entities could include
43 implementing standards for benefits and physician payment arrangements of plans offered through
44 an exchange. Accordingly, it will be critical that these processes are open to relevant stakeholders,
45 to ensure that any exchange works in the best interests of patients, that physician choice of practice
46 is upheld, and that the physician-patient relationship is protected.

1 RECOMMENDATIONS

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The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) adopt the following principles for the operation of health insurance exchanges:
 - a) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.
 - b) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians.
 - c) Physician and patient decisions should drive the treatment of individual patients.
 - d) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.
 - e) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. (New HOD Policy)
 - f) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.
2. That our AMA reaffirm Policy H-373.998[2], which supports patient choice and empowering patients with incentives and understandable information about fees and prices. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy H-165.846[4], which supports transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-185.975 addressing health plan transparency and publication of their payment policies, rules, and fee schedules for physicians. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-385.926, which supports physician freedom of practice. (Reaffirm HOD Policy)

Fiscal Note: Staff cost estimated to be less than \$500 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.