

Improving the Health Insurance Marketplace

Health insurance exchanges

Longstanding AMA policy supports individually owned health insurance, with affordable choices available on the individual market. The establishment of health insurance exchanges provides a patient-friendly market for patients to choose and purchase individually owned health insurance, while increasing competition among health plans based on quality and price.

The AMA supports: the open marketplace model for health insurance exchanges; central physician representation in health insurance exchange governance structures; adequate provider networks in exchanges; sustainably funding exchange operations; and the provision of real-time information to physicians regarding patient health insurance coverage to manage patient churn between public programs and private health plans.

The American Medical Association (AMA) envisions health insurance exchanges as marketplaces through which individuals and families can choose and purchase affordable health insurance coverage that meets their health care needs. Health insurance exchanges should allow individuals and families to make choices from among competing health plans based on quality and price. They also extend health insurance coverage and benefits to millions of individuals who have been uninsured.

Patient Protection and Affordable Care Act provisions

- The Patient Protection and Affordable Care Act (ACA), Public Law 111-148, included provisions for states to establish American Health Benefit Exchanges (AHBE) and Small Business Health Options Program (SHOP) Exchanges. Individuals and small employers with no more than 100 employees will be able to purchase coverage on these exchanges.
- The Secretary of the U.S. Department of Health and Human Services (HHS) is required to establish and operate an exchange in states that do not elect to establish an exchange.
- The exchanges must be administered by either governmental or non-profit entities.
- Individuals eligible to purchase coverage on the AHBE exchanges include U.S. citizens and legal immigrants who do not have access to affordable coverage offered by their employers.
- Eligible individuals with incomes between 100 percent and 400 percent of the federal poverty level (FPL) can receive premium credits and cost-sharing subsidies to assist with the purchase of coverage through AHBE exchanges (see “Health insurance subsidies” in this series). Eligible individuals include those with incomes between 100 percent and 133 percent FPL who reside in states that do not implement the Medicaid expansion outlined in the ACA.
- The ACA also created four levels of plans to be offered through the exchanges, as well as in the individual and small group markets.
 - All categories provide coverage of at least the essential benefits package but differ as to the level of benefits and costs covered (see “Essential health benefits” in this series).
 - The bronze plan, which represents minimum creditable coverage, covers 60 percent of benefit costs including out-of-pocket limits of no more than \$6,850 for individuals and \$13,700 for families in 2016.
 - The percentage of benefit costs covered increases to 70 percent in the silver plan, 80 percent in the gold plan and 90 percent in the platinum plan.
 - A catastrophic plan is also available in the individual market for young adults age 30 or younger and individuals exempt from the individual responsibility requirement. Individuals affected by health insurance policy cancellations also can qualify for a temporary hardship exemption to allow them to purchase catastrophic plans.

- Health insurance plans must be designated as “qualified health plans” (QHPs) to participate in any exchange. To achieve the QHP designation, plans must:
 - Be certified by the state exchange and provide at least the essential health benefits package
 - Be offered by a health insurance issuer that is licensed and in good standing in the exchange state, agrees to offer at least one silver and one gold plan, and complies with the HHS and exchange regulations

Strategies to foster healthy markets

Support the open marketplace model for health insurance exchanges

The AMA believes that exchanges should serve as open marketplaces to help maximize competition between health insurance issuers and patient choice of health plan. An open marketplace exchange generally will allow any willing QHP to enter the exchange marketplace. It therefore would facilitate competition between QHPs based on price, quality and transparency. In order for an open marketplace exchange to succeed, the standards and regulation developed for QHPs must include strong patient and physician protections.

The other leading alternative, an active purchaser exchange, would selectively contract with QHPs. If active purchaser exchanges negotiate price and other issues with plans seeking to be QHPs, then they are likely to eliminate certain options for patients as well as restrict the benefit structures or cost-sharing options. As a result, patient choice of health plan in active purchaser exchanges could be severely restricted. In addition, an active purchaser exchange could exacerbate unprecedented health insurance marketplace concentration.

Ensure physician representation in health exchange governance, development and operation

The AMA believes that including actively practicing physicians and patients in the governance structures of the exchanges is essential in exchange implementation to ensure that key issues such as benefit structure, QHP certification, and physician payment are effectively and astutely addressed. Practicing physicians are unique in their ability to provide exchanges feedback from the front lines.

Promote network adequacy

The success of exchanges depends in large part on the strength of the provider networks of their participating plans. The AMA advocates that insurance regulators and patients have access to the information necessary to determine whether the network includes a sufficient number of primary care and specialty physicians and other health care providers. The goal is to ensure that all enrollees are able to receive all covered services in a timely and geographically accessible basis at the preferred in-network rate. Such information is essential to patients so they can know which health plans their physicians are participating in before enrolling. Patient information should also detail the education and training of the physicians and other health care professionals within a plan’s network.

Manage patient churn

The AMA believes that the issue of patient churn between public programs and private health plans is one of the most challenging issues physicians and patients face with the implementation of health insurance exchanges and the Medicaid expansion. If not effectively addressed, patient churn could significantly affect the continuity and quality of patient care. When patients churn from one plan to another, they can lose access to their physicians if their physicians do not participate in the new plan. As a result, churning can cause patients to lose their medical home. For physicians, churning could impact the ability to receive payment for the care and services provided, especially if patients churn from one plan in which a physician participates to another plan in which a physician does not. With patients cycling through various eligibility levels over time, physicians need to have real-time information regarding the coverage of every patient.

Provide sustainable funding for exchange operations

The ACA requires that exchanges must be selfsupporting over the long term. States have a multitude of options to financially support their exchanges, including imposing fees on health insurance issuers, earmarking funds from general revenues and using proceeds from tobacco taxes. The AMA strongly opposes the imposition of provider taxes as a possible funding stream for exchanges.

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