



Background Information: Health Insurance Exchanges

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Below are a number of resources intended to help AAFP chapters promote the formation of state-based health insurance exchanges in a manner that emphasizes primary care.

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BACKING UP THE AAFP EXCHANGE PRINCIPLES

1) FAIR REPRESENTATION OF STAKEHOLDERS

[The Affordable Care Act](#), March 2010

Section 1311(d)(6) of the ACA requires exchanges to consult with a broad range of stakeholders.

[Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues](#), *The Commonwealth Fund*, July 2010

This paper explains how 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.

["Insurance Exchanges under Health Reform: Six Design Issues for the States"](#), *Health Affairs*, June 2010

According to this article, an exchange's board of directors should be appointed based on relevant expertise, representing a broad spectrum of interests. It suggests the model of a semi-independent government authority, managed outside the civil service pay structure and appointed by elected officials.

[Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues](#), *The Commonwealth Fund*, September 2010

This article contests that providers and insurers should not serve on an exchange's board of directors due to potential conflicts of interest but suggests they should both serve on an advisory board. An advisory board could represent insurer, producer, and provider interests while avoiding a conflict of interest. Conflicts of interest should also be avoided by enacting legislation or incorporating by reference existing state legislative provisions that would prohibit exchange managers or board members from moving directly to or from the insurance industry.

2) PAYMENT FOR THE PATIENT-CENTERED MEDICAL HOME (PCMH) & ENHANCED ACCESS

[The Affordable Care Act](#), March 2010

Under section 1301, the ACA allows qualified health plans to offer coverage through a primary care medical home, also known as a patient-centered medical home.

["Driving Quality Gains and Cost Savings through Adoption of Medical Homes."](#) *Health Affairs*, May 2010

This analysis determines that PCMHs can reduce the frequency and length of emergency room visits and hospitalizations and successful demonstrations have at least four commonalities, including expanded access to care and financial incentives for providers. Expanding access requires providing round-the-clock access to a health care provider. At a minimum, any approach to expanded access must make certain that a patient's health questions that arise in the evenings or on weekends are not directed to emergency rooms. Expanded access should include not only face-to-face communication but additional modes such as e-mail and telephone. Incentives to motivate behavior change among providers need to be targeted, but not necessarily large. Research suggests that physicians respond to financial incentives designed to lower health care spending. Modest per member per month payments appear necessary to encourage physicians to adopt the care coordination mechanisms needed for medical homes. Data shows there is little convergence over what type of incentive—per member per month payments or payment for performance—is likely to yield better results. However, most pilots have not included significant performance pay or downside risk as part of their models. As one benchmark, North Carolina's per member per month payments were generally under \$10. Other experts suggest that just a few dollars per member per month may be necessary, with the optimal amount depending on the expected average utilization among members.

["The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers."](#) *Health Affairs*, May 2010

This article finds PCMHs restrain cost increases and enhance the quality of care provided, particularly for those with chronic conditions. Financing reform is necessary to ensure that the benefits recouped align with the investments made. In addition to finding ways to shift downstream savings from reduced hospitalization and emergency department use upstream to primary care, other financing reform is required to support primary care infrastructures, particularly in staffing, electronic health records, and change management. Savings in smaller independent practices with fewer supports may take much longer to achieve.

[Principles for Physician Payment Reform to Support the Patient-Centered Medical Home](#), *AAFP Policy*, 2010

A physician payment system should:

- (1) Appropriately recognize the value of whole-person care delivered in a PCMH including physician and non-physician work such as: (a) face-to-face evaluation and management services; (b) patient care management that falls outside of payment for face-to-face visits, e.g. proactive preventive and chronic care management; (c) "medical neighborhood" care coordination (e.g. among hospitals, consultants, ancillary providers, and community resources); and (d) remote monitoring of biometric clinical data and patient support;
- (2) Reward PCMH activities which improve patient outcomes and reduce total health care spending through incentives that: (a) allow physicians to share in savings from reduced hospitalizations, emergency room overuse, and high cost procedures; (b) reward measurable and continuous quality improvements; (c) support physicians in engaging patients as partners through shared decision-making and the development of strong, enduring, healing relationships; (d) support the efficiencies of team-based care; (e) support the use of evidence to guide clinical decision making; and (f) support the provision of comprehensive primary care services;
- (3) Compensate for the physician practice's investment in technology and services which enhance patient access and improve care coordination such as: (a) improved patient care communication, for example through a secure, Web-based patient portal that supports synchronous or asynchronous e-mail and virtual visits and telephone consultation; (b) acquisition and use of health information technologies (e.g. patient registry systems, evidence-based clinical decision support, electronic health records, etc); and (c) investment in infrastructure for practice transformation and innovation, e.g. staff training, work flow redesign and practice recognition requirements;

- (4) Include a transparent process that ensures the payment model accurately accounts for the cost of operating an efficient practice including but not limited to: inflation expense, patient demographics (socioeconomic status, age, and gender), practice setting (rural/urban) and disease severity/case mix;
- (5) Promote accountability for achieving better results by linking a portion of payment to reporting on appropriate evidence-based measures of care, including structural, process and outcomes measures. Ensure that performance measures included in payment and reporting systems are valid and meaningful to all stakeholders and payment is more than the additional costs of reporting;
- (6) Include standardized administrative requirements and business rules across all payers including, but not limited to: (a) Standardized interfaces for eligibility, benefits, deductibles, and real time claim submission/payment; (b) Standardized reporting requirements; and (c) Regional harmonization of measures;
- (7) Allow for hybrid approaches to payment to counter-balance unintended consequences associated with using any single approach to payment; and
- (8) Achieve an appropriate balance in income between primary care and sub-specialty physicians as a means to help ensure that there are sufficient primary care physicians.

3) STANDARDIZED CONTRACTING

[Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues](#), *The Commonwealth Fund, September 2010*

This report recommends that state regulation of the individual and small-group market outside the exchange, to the extent possible, should be identical to corresponding regulation inside the exchanges to avoid adverse selection. It explains that under the ACA:

- Most of the insurance reforms imposed by the legislation apply both within and outside the exchange. These include a number of provisions that might encourage adverse selection against the exchange if applied only within the exchange, such as the prohibition of health status underwriting.
- Individual and small-group plans, both within and outside the exchange, must cover the same defined “essential health benefits.” Out-of-pocket limits are also the same inside and outside the exchange.
- With the exception of enrollees in grandfathered plans, health insurance issuers must treat all individual enrollees in their plans (inside and outside the exchange) as one single risk pool and all small-group enrollees as another single risk pool, or, if the state elects, treat members of both pools as a single risk pool.
- Issuers of qualified health plans must charge the same premium rate for a plan inside and outside the exchange.
- The ACA creates three risk-adjustment programs, two transitional and one permanent, which should reduce adverse selection against the exchange. If plans outside the exchange attract a significantly healthier population than plans in the exchange, they will need to compensate the plans in the exchange.
- Finally, and most importantly, the ACA’s premium assistance credits and cost-sharing reduction payments will be accessible only to individuals enrolled in qualified health plans through exchanges. Tax credits will also be available to small employers only through the exchange.

[Managed Care State Laws and Regulations, Including Consumer and Provider Protections](#), *National Conference of State Legislatures, May 2008*

This resource shows that 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.

[Principles of Interaction between Family Physicians and Health Plans](#), *AAFP Policy, 2009*

AAFP policy states any contract that a health plan offers to physicians or physician organizations must specify the insurance products covered by the contract. No contract should obligate those physicians or physician organizations who sign the contract to participate in insurance products not specifically identified by the contract. Physicians should have adequate time to evaluate a new product prior to being added to any new provider panel.

4) SET PRIMARY CARE TARGETS

[“Rhode Island’s Novel Experiment to Rebuild Primary Care from the Insurance Side”](#), *Health Affairs, May 2010*

This article explains how Rhode Island successfully implemented the relatively new strategy of setting primary care spending targets 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. In 2008, Rhode Island insurers spent 5.9 percent of their medical services expenditure on primary care, which compared poorly to benchmark data from other high-performing health systems. For example, Geisinger Health System’s health plan in Pennsylvania reported using nearly nine percent of its total spending on primary care. The Rhode Island [target](#) is now 10.9 percent, which is the current rate plus five percentage points, as set in affordability standards. First, each insurer’s proportion of medical expense to be allocated to primary care for the twelve months starting January 2010 was to be one percentage point higher than actual spending for

the twelve months starting January 2008. This proportion was then to increase by one percentage point per year for five years.

The increase in primary care spending is critical. The amount spent on primary care for the fully insured commercial population for 2009 was estimated to be approximately \$52 million. Therefore, to get from 5.9 percent to 6.9 percent of overall expenditures on health care, the additional primary care spending was estimated to be \$11 million in 2010, factoring in overall health care inflation. Similar increases would be \$24 million in 2011 and \$39 million in 2012, in terms of additional primary care expenditures on the 2009 base. The approach is admirably simple: Estimate current expenditures, then force the limited number of commercial companies in the fully insured marketplace, over which the state's insurance commissioner has direct control, to boost payments and identify what is being supported. It is, in effect, attempting to redress the Medicare's resource-based relative value scale (RBRVS) valuation process, which had the unintended effect of devaluing primary care. It also bypasses the usual approach of contractual negotiations between private health plans and providers, which reward provider size and market share, as opposed to high-quality care—especially high-quality primary care.

5) REQUIRE ROBUST PRIMARY CARE-BASED ESSENTIAL BENEFITS

["Primary Care and Why It Matters for U.S. Health System Reform," Health Affairs, May 2010](#)

According to this study:

- Multiple investigators from various disciplines have found that when people have access to primary care, treatment occurs before more severe problems can develop.
- People who receive primary care also have fewer preventable emergency department visits and hospital admissions than those who do not.
- Primary care clinicians use fewer tests, spend less money, and protect people from overtreatment more than do the subspecialists from whom people seek routine care.
- Particularly for the poor, access to primary care is associated with improved outcomes, more complete immunization, better blood pressure control, improved dental health, reduced mortality, and improved quality of life.
- People with a regular source of primary care also receive more preventive services than those who lack such a source of care.
- Higher levels of primary care in a geographic area are associated with lower mortality rates, after important effects of urban-rural differences, poverty rates, education, and lifestyle factors are controlled for.
- In addition, having a primary care physician is associated with increased trust and treatment compliance.
- Primary care enhances the performance of health care systems. It is not the solution to every health-related problem, but few, if any, health-related problems can be adequately addressed without it.

The article also finds that doubling primary care financing, to 10–12 percent of total health care spending, would be likely to pay for itself, via resulting reductions in overall health spending. This construct has been endorsed by many Fortune 100 companies and the Medicare Payment Advisory Commission (MedPAC). Early results from ongoing demonstrations include total health care savings of 15 percent or more, reductions in hospitalizations and emergency visits, and even reductions in mortality. Early demonstrations of the patient-centered medical home, particularly those embedded within larger more integrated systems, are illuminating pathways to better care and savings. But the pathways are achievable on a national scale only through payment reform and change facilitation.

["Would Having More Primary Care Doctors Cut Health Spending Growth?" Health Affairs, September 2009](#)

This article, along with others, finds that a higher proportion of PCPs in an area is associated with a lower level of spending. For example, Hospital Referral Regions (HRRs) in lower-spending quintiles of Medicare end-of-life have fewer specialists and more family practitioners and general practitioners than HRRs in higher-spending quintiles. Similarly, states with a greater proportion of general practitioners have lower spending per Medicare beneficiary compared with other states.

["Primary Care—Will It Survive?" New England Journal of Medicine, August 2006](#)

Fixing primary care requires actions on the part of primary care practices (microsystem improvement) and the larger health care system (macrosystem reform). A covenant is needed between those who pay for health care and those who deliver primary care: primary care must promise to improve itself, and in return, payers must invest in primary care. Employers and insurers, public and private, may reap a return on investment by fostering a more effective primary care sector that will reduce health care costs. The public would benefit from microsystem improvement, with fewer appointment delays, higher quality, and more meaningful interpersonal relationships. Even specialists might recognize that they would suffer if primary care deteriorates, being forced to coordinate care and confront psychosocial issues in patients with

multiple acute and chronic conditions rather than focusing on diagnosing and managing specific diseases within their scope of expertise.

[Primary Care, AAFP Policy, 2006](#)

According to the AAFP definition, primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal physician often collaborating with other health professionals, and utilizing consultation or referral as appropriate. Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care.

6) PRESUME ELIGIBILITY

[“Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges.”](#) Health Affairs, February 2011

This article explains how disruptions in insurance coverage not only have adverse effects on access to care and administrative costs, problems can arise simply from changes in health plans, even without gaps in coverage. Although this examines how income shifts potentially can result in coverage and care disruptions specific to Medicaid under the *Affordable Care Act*, lessons can be taken from this article on disruptions in coverage both public and private. One concern is real-time reporting of income and adjustment of subsidies for insurance coverage based on income. The second major concern is the issue of timing of coverage. Medicaid coverage can be retroactive up to ninety days before the date on which eligibility is actually determined. On the other hand, if typical industry standards are used, plans participating in the exchange would begin coverage the first of the month after an individual becomes eligible. To ensure that movement from Medicaid to an exchange plan does not lead to a break in coverage, states may need to require enrollment in plans through the exchange to be retroactive to the date of first eligibility for people transitioning from Medicaid, or to extend Medicaid coverage until exchange coverage takes effect.

The most crucial aspect of income fluctuation is its potential effect on the continuity and quality of care for individuals and families who shift between Medicaid and exchange coverage. To the extent that the same plans with the same provider networks participate in both the exchange and Medicaid markets, the practical impact of coverage changes might be markedly reduced. For this to happen, it is important for the secretary of health and human services to take steps to align, as much as possible, the conditions of participation for both exchange-qualified health plans and Medicaid managed care organizations, to promote dual market participation. States also could consider the development, in collaboration with Medicaid plans and health insurers, of products that are certified to operate in both markets. To the greatest extent possible, these plans would share common coverage terms, provider networks (especially participation by essential community providers), administrative systems, consumer and patient protections, and quality and performance measures.

[Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures and Cost-Sharing Practices in Medicaid and CHIP](#), Kaiser Commission on Medicaid and the Uninsured, January 2011

This document examines variation in the eligibility rules of state Medicaid programs. With the addition of Iowa, Montana, and Ohio in 2010, as of January 2011, 13 states use presumptive eligibility to enroll children in both Medicaid and CHIP and three additional states apply the policy to Medicaid only. Furthermore, 31 states use presumptive eligibility to enroll pregnant women in coverage following Connecticut's adoption of the option in 2010. Presumptive eligibility empowers certain qualified entities, such as hospitals or community health centers, to make preliminary eligibility decisions so children and pregnant women can get care while they complete the regular Medicaid and CHIP application process. The ACA extended the option to use presumptive eligibility to enroll adults (previously the policy option was only available for children and pregnant women) and will authorize hospitals that are Medicaid providers to make presumptive eligibility determinations in 2014.

[Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP, and Subsidies in the Exchanges](#), Kaiser Family Foundation, August 2010

This brief explains various eligibility and enrollment provisions in the ACA. Section § 2202 expands presumptive eligibility for Medicaid applicants. At state option, all hospitals participating in a state Medicaid program can grant presumptive eligibility to all Medicaid eligible populations (not only pregnant women and children). This option is effective January 1, 2014.

[Learn about...New Consumer Benefits under the Affordable Care Act: Lowering Your Cost for Preventive Services, Department of Health & Human Services, January 2011](#)

This HHS-issued paper explains how the *Affordable Care Act* helps make wellness and prevention services affordable and accessible by requiring many health plans to cover all evidence-based, recommended preventive services and by eliminating cost-sharing. Anyone enrolled in an employment-based group health plan or an individual health insurance policy created after March 23, 2010, can receive certain recommended preventive services without a copayment, coinsurance, or deductible.

7) REWARD QUALITY

[Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues, The Commonwealth Fund, July 2010](#)

This brief explains how reporting to multiple payers on different measures creates an undue administrative burden on physician practices. The 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.

[“Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges.” Health Affairs, February 2011](#)

This article examines a central goal of health reform—improving the quality and efficiency of care. High-quality care is by definition continuous over time. Quality-measurement systems will need to be particularly sensitive to plan and provider performance for patients whose coverage changes as they churn in and out of programs, because the incentive may be to provide few services and to delay care on the assumption that they will soon be gone. Discontinuities may also lead to inadequate clinical follow-up of chronic diseases, especially since acute deteriorations in health status may often be accompanied by changes in income and eligibility due to job loss. Monitoring for the risk of underservice has been a challenge for Medicaid managed care plans for years as a result of unstable eligibility; Medicaid-exchange churning is an extension of this challenge.

[A Broad and Structured Approach to Improving Patient Safety and Quality: Lessons from Denver Health, Health Affairs, April 2011](#)

This article finds that the financial rewards are an important component to Denver Health’s experience in successfully improving quality of care. The “right reward” component featured monetary awards given to teams that substantively addressed a financial or quality issue. Of the 133 cash awards given to date, 57 were given for quality initiatives. These payments underscored that quality and safety were important, along with financial outcomes.

[Physician Payment, AAFP Policy, 2009](#)

The AAFP believes that any payment system must address:

- (1) Quality care, access to care and positive health outcomes must be the primary goals of any payment system.
- (2) The unique partnership embodied in the doctor/patient relationship must be preserved.
- (3) A payment system must be based on continuing, comprehensive care rather than fragmented care and should encourage treatment on an ambulatory basis rather than in a costly institutional setting.
- (4) There must be recognition of the value of prevention, early diagnosis and early treatment with appropriate incentives to the patient and to the physician to participate.
- (5) Increased emphasis must be placed on payment for the cognitive portion of physician services, recognizing that this will likely result in lower payment for other services.
- (6) Physicians should be paid to perform services, both cognitive and procedural, for which they have documented training and/or experience, demonstrated abilities and current competence.
- (7) Certain factors (e.g., medical resources, locales, etc.) that diminish access to needed and quality medical care exist and may arise in the future. In these instances, national policies, such as a multiplier to the Resource-Based Relative Value Scale (RBRVS), that provide appropriate payment incentives may be given to physicians who will serve these underserved needs or areas.
- (8) There must be substantial physician involvement in determining appropriate values to be assigned to payment for various physician services.
- (9) Sufficient flexibility must be built into the system to recognize individual variation inherent in medical encounters, including the patient’s health status or special circumstances, complications which may arise, severity of illness and other reasons.

- (10) Individual physicians in independent practice must retain the right to set their own charges and the option to have those charges differ from the amounts scheduled for payment. In determining their charges, physicians' considerations should include, but not be limited to:
 - a. the amount of skill and/or special training required;
 - b. the amount of time spent providing the service;
 - c. the risk involved in supplying the service;
 - d. special economic considerations for the financially disadvantaged;
 - e. supplies and equipment used;
 - f. the use of ancillary personnel in providing the service; and
 - g. costs of maintaining an appropriate facility for providing the service.
- (11) Assurance of quality and appropriate utilization of services through peer review mechanisms shall remain the responsibility of the medical profession at the local level, with sufficient opportunity for involvement by all specialties.
- (12) Any payment system must include provisions for annual reevaluation to keep the system current, so it reflects changing economic factors affecting the cost of delivering services.
- (13) Any payment system which utilizes or contracts for case management services should pay appropriately for these services.
- (14) Payment for services should be established according to an RBRVS which takes into account the unique practice expenses and professional liability costs of primary care physicians and uses a single conversion factor for all physician services.
- (15) The value of family physicians' role in diagnosing, managing, and coordinating the delivery of mental health services should be recognized by adequate payment by all payors responsible for mental health coverage. The role and payment of family physicians in the delivery of mental health services should not be limited by plan design.
- (16) Periodic preventive services should be paid by all public and private insurers when performed in the same anniversary month as they were last performed.
- (17) Physicians should be paid for electronic communication, consultations, and care coordination services that they provide for the medical management of their established patients as a separate service unrelated to an evaluation and management (E/M).

[Pay-for-Performance](#), AAFP Policy, 2010

The AAFP supports pay for performance (PFP) programs that: (1) Focus on improved quality of care; (2) Support the physician/patient relationship; (3) Utilize performance measures based on evidence-based clinical guidelines; (4) Involve practicing physicians in program design; (5) Use reliable, accurate, and scientifically valid data; (6) Provide positive physician incentives; and (7) Offer voluntary physician participation. PFP programs should provide incentives to physician practices for: (1) Adoption and utilization of health information technologies; (2) Implementation of systems to improve the quality of patient care and patient safety; (3) Adhering to evidence-based clinical guidelines; (4) Improving performance and meeting performance targets; (5) Improving patient access to appropriate and timely care; and (6) Measuring and attempting to improve patient acceptance and satisfaction with their care.

8) PROTECT CONSUMERS & PHYSICIANS

[Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP and Subsidies in the Exchanges](#), The Children's Partnership and the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, August 2010

This brief deconstructs Medicaid eligibility and enrollment provisions of the ACA, which requires states to create enrollment systems that ensure that applicants are screened for all available health subsidy programs and enrolled in the appropriate program, with minimal collection of information and documentation from applicants. 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. Helping consumers understand their options, helping families apply online, providing a single, streamlined application form, and reducing administrative burdens are included the ACA's consumer friendly provisions.

[Learning about...New Consumer Protections under the Affordable Care Act: Protecting Your Choice of Health Care Providers](#), Department of Health & Human Services, January 2011

This HHS-issued paper says that people who have a regular primary care provider are more than twice as likely to receive recommended preventive care, are less likely to be hospitalized, are more satisfied with the health care system, and have lower costs. The new rules created under the ACA permit choice of any available participating primary care provider to

be your primary care doctor. The ACA also ensures patients' right to appeal to an independent entity when your plan or insurer denies payment for a service or treatment.

[Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues](#), *The Commonwealth Fund*, September 2010

This paper examines a host of transparency and disclosure requirements provided in the ACA that will significantly expand the amount of information available to insurance consumers. Exchange-based plans have additional reporting requirements and must provide information on the availability of in- and out-of-network providers. Exchange plans are also required to provide information on cost-sharing for out-of-network coverage and on enrollees' and participants' rights, as well as additional information on cost-sharing with respect to specific services from specific providers if an enrollee requests it. Qualified health plans should also be required to disclose their actuarial value.

The ACA requires HHS to develop a survey system to evaluate the level of enrollee satisfaction for each qualified plan offered through the exchange that had more than 500 enrollees in the previous year. Exchanges are supposed to make comparative consumer satisfaction information available to individuals and employers through a Web portal in a manner that allows easy comparison of plans. Satisfaction surveys should both address all aspects of plan performance that are important to consumers and allow consumers to provide an overall assessment of satisfaction in order to facilitate easy comparison. Consumers should be able to view the aggregated results of the survey information in much the same way that they can view user ratings of "apps" on the Apple Store or books on Amazon.com. Both a compilation and a breakdown of the consumer ratings should be presented.

EXCHANGE BASICS

[The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned](#), *Georgetown University Health Policy Institute Center for Children and Families (CCF)*, March 2011

This 16-page brief examines three primary dimensions of the existing exchanges in Massachusetts and Utah: the quality and choice of plans, the affordability of coverage, and ease of enrollment.

[A Profile of Health Insurance Exchange Enrollees](#), *Kaiser Family Foundation (KFF)*, March 2011

This 18-page report describes those 24 million Americans expected to purchase private health insurance through the new Health Insurance Exchanges. Among the key findings is that those purchasing coverage are likely to be relatively older, less educated, and more racially diverse and report to have poorer health, but have fewer diagnosed conditions than those who currently have private insurance.

[Health Insurance Exchange Basics](#), *NASHP*, February 2011

This six-page brief sets forth the major requirements for exchanges as described in the federal law. These requirements provide states with sufficient guidance to define the overall parameters of their exchanges, recognizing that states will likely revisit or refine these decisions as the federal law is clarified through federal regulations.

[Designing an Exchange: A Toolkit for State Policymakers](#), *National Academy of Social Insurance (NASI)*, January 2011

This 52-page toolkit builds off the NAIC model legislation, offering options in a number of key areas, including governance, establishment of a Small Business Health Options Program (SHOP), eligibility determination and enrollment, certification of qualified health plans, and coordination with Medicaid and CHIP.

[American Health Benefit Exchange Model Act](#), *National Association of Insurance Commissioners (NAIC)*, November 2010

This 11-page model legislation can serve as a foundation from which states can build the structure and form governance for an exchange.

[Implementing Health Insurance Exchanges: A Guide to State Activities and Choices](#), *Families USA*, October 2010

This 36-page report describes the requirements in the Affordable Care Act that all the new exchanges must meet. It then outlines activities and choices that states face as they design exchanges, along with various issues that consumer advocates should consider.

AVOIDING ADVERSE SELECTION

[Health Insurance Exchanges: State Roles in Selecting Health Plans and Avoiding Adverse Selection](#), Commonwealth Fund, February 2011

This resource provides guidance on how active states should be in selecting health plans, avoiding adverse selection, and the timeline to implement an exchange as established by the ACA.

[States Should Structure Insurance Exchanges to Minimize Adverse Selection](#), Center for Budget and Policy Priorities (CBPP) August 2010

This nine-page document recommends four steps that states should take when setting up their exchanges to minimize the risk of adverse selection—a factor that led to the failure of several state-based exchanges in the past.

[PPACA Requirements for Offering Health Insurance Inside versus Outside an Exchange](#), Congressional Research Service (CRS), June 2010

This 10-page brief lists the ACA's private health insurance market reforms that must be in effect by 2014 for new plans in the nongroup and small group markets—with a focus on distinguishing between those that apply inside versus outside an exchange. As such, this report does not go into detail in describing the specific provisions that apply but rather discusses the impact on new plans.

EXCHANGES & COVERAGE OPTIONS

[Medicaid's Role in the Health Benefits Exchange](#), National Academy of State Health Policy (NASHP), Robert Wood Johnson Foundation (RWJF), April 2011

This 38-page paper explains how Medicaid fits into state exchanges meeting the ACA requirements with regards to eligibility, enrollment and outreach, health plan contracting, standards, and requirements, benefit package design, and exchange infrastructure.

[Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid](#), RWJF State Coverage Initiatives (SCI), Urban Institute, March 2011

This 25-page report makes projections on available funding for exchanges to serve an expanded Medicaid population and provides state-by-state analysis of changes in funding and enrollment with the enactment of the ACA.

[Value-Based Health Care Purchasing: Essential Health Benefits and State Health Insurance Exchanges](#), Health Reform GPS, January 2011

This brief summarizes the requirements for health insurance exchanges established under the ACA and provides details on the implementation process. Key issues identified include: (1) positioning exchanges to support value-based health care purchasing, (2) determining essential benefits and qualified health plans in relation to value-based purchasing, (3) promoting value-based purchasing techniques to serve vulnerable populations, and (4) carrying over value-based purchasing strategies into the Medicaid market.

[Health Insurance Exchanges: New Coverage Options for Children and Families](#), Georgetown University CCF, August 2010

This 11-page report determines that from the consumer perspective, the ultimate success of the exchanges will come down to how easy it is to enroll and maintain coverage that is affordable and accessible. Fortunately, states have a long history of applying outreach and enrollment initiatives to subsidized coverage programs.

EXCHANGES & SMALL BUSINESSES

[Questions for ACS CAN Evaluative Framework for Assessing SHOP and Health Benefits Exchange Proposals](#), American Cancer Society Cancer Action Network (ACS CAN), December 2010

Reviewing availability, affordability, adequacy of coverage, administrative simplicity, governance and financing, this 18-page resource—mostly made up of a chart—illustrates issues to be considered in establishing an exchange.

[Tax Subsidies for Individuals and Families Who Purchase Coverage Through State Health Insurance Exchanges](#), Health Reform GPS, December 2010

This paper explains the refundable tax credit available to individuals without affordable employer coverage ineligible for Medicaid. Determining eligibility, reporting changes in income to avoid recoupment, and coordination with Medicaid are identified as the key issues.

[Establishing State Health Insurance Exchanges: Implications for Health Insurance Enrollment, Spending, and Small Businesses](#), RAND Corporation, 2010

This 87-page paper analyzes the effects of the ACA on employers and enrollees in employer-sponsored health insurance, with a focus on small businesses and businesses offering coverage through health insurance exchanges. Outcomes assessed include the proportion of nonelderly Americans with insurance coverage, the number of employers offering health insurance, premium prices, total employer spending, and total government spending relative to possible spending without the enactment of the ACA.

TECHNICAL RESOURCES FOR STATES

[Building an Effective Health Insurance Exchange Website](#), BCBS of Massachusetts Foundation, Health Connector, RWJF, April 2011

This 157-page report provides an in-depth look at building a state health insurance exchange based on the Massachusetts Connector. Strategies, as well as tools, resources and other documents, are provided to help other states implement their own websites.

[Health Insurance Exchanges: Implementation and Data Considerations for States](#), SHADAC, October 2010

This 12-page issue brief presents key implementation and data considerations for states as they contemplate the creation and role of exchanges. In addition, this brief profiles four state exchanges—Massachusetts Health Connector, Utah Health Exchange, Connecticut Business and Industry Association (CBIA) Health Connections, and Washington Health Insurance Partnership (HIP)—launched under state efforts that predated the ACA.

[Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues](#), The Commonwealth Fund, September 2010

This 72-page report focuses on eight of the most difficult issues that the states and the federal government face in implementing the exchanges: governance of the exchanges; avoidance of adverse selection; making self-funded plans compatible with exchanges; making exchanges attractive to employers; exchanges' use of their regulatory authority; determining the information that exchanges must make available to consumers and employers; the exchanges' role in making eligibility determinations for premium tax credits and cost-sharing reduction payments and their relationship with public insurance programs; and reducing administrative costs.

[State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals](#), RWJF SCI, AcademyHealth, September 2010

This 49-page paper provides guidance to states interested in: maximizing coverage and access to care; reforming health insurance to function more like a traditional market; holding insurers accountable for providing consumers with high-quality, affordable health coverage; restructuring health care delivery and financing to slow cost growth while improving quality; and reducing budget deficits.

[Health Benefit Exchanges: An Implementation Timeline for State Policymakers](#), RWJF, AcademyHealth, July 2010

This 16-page brief provides a timeline for states to use in planning for the development of exchanges under the ACA, emphasizing the need for strategic planning, sequencing and coordinating inter-related tasks, and the effort required to procure the services of and manage relationships with large vendors.

[Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues](#), The Commonwealth Fund, July 2010

This 44-page report identifies earlier attempts' problems, enumerates the key issues that are critical for overcoming those problems, analyzes in detail the ACA's provisions addressing these issues, and discusses further policy options.

[Patient Protection and Affordable Care Act of 2009: Health Insurance Exchanges](#), NAIC, April 2010

This 10-page chart deconstructs all provisions in the ACA concerning exchanges, providing details, section numbers and effective dates.

AAFP RESOURCES

[Health Insurance Exchanges: Variation in State Efforts](#), March 2011

This 15-page report provides background information on the varying forms insurance exchanges can take as well as a brief history, including provisions under federal health reform, existing exchanges and previously failed attempts at exchanges. State efforts to create—or consider creating—an exchange are also provided.

[2011 State Legislation: Health Insurance Exchanges](#), March 2011

This 23-page document lists all 2011 state legislation concerning studying, planning or creating a state exchange or participating in a regional exchange. The document also provides an overview of provisions provided in the *Affordable Care Act* (ACA) that many states are incorporating into their legislative language.

[Health Insurance Exchanges](#), August 2010

This 21-slide presentation was given by AAFP board chair Lori Heim, MD at a 2010 HHS conference on health insurance exchanges and quality improvement. She provides background on what defines an exchange, issues to consider in exchange design, and provider concerns.

[Emerging Issues: Health Insurance Exchanges](#)

This section of aafp.org falls under the “State Advocacy” heading. Members and chapters can refer to the webpage for new and updated materials on exchanges and other emerging issues.

[Health Insurance Exchanges Under PPACA](#)

This also can be found within the State Advocacy section of aafp.org under “State Implementation of Federal Health Reform.” The webpage provides up-to-date materials produced by AAFP staff to help inform chapters of state implementation, as well as directs them to other organizations’ ACA resources.

FEDERAL RESOURCES

[Secretary Sebelius’s Letter to Governors](#), U.S. Department of Health and Human Services (HHS), February 2011

U.S. HHS Secretary Sebelius sent this three-page letter to governors in response to state concerns regarding flexibility in: (1) designing exchanges under the ACA, (2) determining essential health benefits, (3) waiving provisions that might inhibit consumer-driven plans, and (4) enrolling Medicaid beneficiaries into private plans without HHS approval. The Secretary’s response explains how the ACA provide states with broad discretion in creating and operating exchanges.

[Health Insurance Exchange Establishment Grants Fact Sheet](#), HealthCare.gov, January 2011

This fact sheet explains how states are utilizing federal planning grants to create exchanges at different paces and moving forward, state will have multiple opportunities to apply for funding through the Exchange establishment process.

[Cooperative Agreement to Support Establishment of State Operated Health Insurance Exchanges](#), Grants.gov, January 2011

Grants.gov provides the full announcement of state exchange establishment grants, allows individuals to sign-up for notification emails, and links to grant applications.

[State Planning and Establishment Grants for the Affordable Care Act’s Exchanges](#), Center for Consumer Information and Insurance Oversight (CCIIO), July 2010

This 20-page PDF explains the application process and materials needed by states that apply for federal grants to plan and establish exchanges.

[Initial Guidance to States on Exchanges](#), CCIIO

Prior to issuing regulations concerning exchanges under the ACA, HHS posted this initial guidance on the CCIIO website. In addition to listing statutory requirements, the resource also provides principles and priorities on which federal funding and technical support will be determined.

[Programs and Initiatives: Health Insurance Exchanges](#), CCIIO

The Health Insurance Exchanges section of the CCIIO website links to resources concerning Early Innovator Grants, Information Technology Systems, Planning and Establishing Grants, and Territory Cooperative Agreements, as well as regulations and guidance, fact sheets and FAQs, and letters and news releases.

OTHER REPORTS ON EXCHANGES UNDER THE AFFORDABLE CARE ACT

[Multi-State Health Insurance Exchanges](#), RWJF, Urban Institute, April 2011

This four-page brief weighs the pros—administrative economies of scale, large metropolitan areas that cross state boundaries, and stable risk pools—versus the complexity of multi-state health insurance exchanges.

[Health Insurance Exchanges – How Economic and Financial Modeling Can Support State Implementation](#), AcademyHealth, RWJF SCI, State Health Access Data Assistance Center (SHADAC), November 2010

This seven-page brief describes some issues states will need to consider as they think about modeling the impact of the ACA. Economic, actuarial and financial data provide a solid, fact-based foundation for the many decisions facing states about key aspects of the health insurance exchanges.

[Update: Health Insurance Exchanges](#), Health Reform GPS, November 2010

This paper outlines the broad concerns states address about designing and operating exchanges, as well as numerous technical issues that can arise.

[Realizing Health Reform's Potential: Health Insurance Exchanges and the Affordable Care Act](#), Commonwealth Fund, November 2010

This webpage provides an archived 60-minute webinar including the audio and presentation slides. Speakers included Timothy Stoltzfus Jost, JD and Robert L. Willett Family of the Washington and Lee University School of Law; Michael T. McRaith, JD, Director of the Illinois Department of Insurance; and Sandra Shewry, MPH, MSW, Advisor of Health Care Reform Implementation at the California Health and Human Services Agency.

OTHER RESOURCES

[Be Strategic with Insurance Exchanges](#), State Refor(u)m

This online forum offers 139 documents, 17 people, 37 states and 226 discussions all pertaining to health insurance exchanges.

[Committees & Activities: Exchanges \(B\) Subgroup](#), NAIC

The Exchanges (B) Subgroup was established under section 1321 of the ACA, requiring the Secretary of HHS, in consultation with the NAIC, health insurance issuers, and consumer organizations, to issue regulations setting standards for the establishment and operation of exchanges. This section of NAIC.org tracks meetings and activities of the subgroup.

[Exchange Resources for States](#), State Refor(u)m

This online forum offers 13 documents, six people, nine states and 28 discussions concerning state-based exchanges.

[HealthCare Notes: Exchanges](#), HealthCare.gov

This link takes you to all documents—including news releases and grant announcements—available on HealthCare.gov that are tagged with the term “exchanges.”

[Health Insurance Exchanges and Insurance Market Reforms](#), RWJF SCI

The SCI program stands ready to help states navigate state health reforms, concentrating on exchanges and related insurance market reforms. SCI offers no cost, personalized technical assistance and various online materials.

[Health Insurance Exchange Resources](#), Families USA

This section of FamiliesUSA.org provides information to prepare states for implementation, along with technical materials that examine the ACA. Agency regulations and guidance are posted as they are issued.

[Health Reform Implementation: State Actions and Legislation Overview](#), National Conference of State Legislatures (NCSL)

This section of NCSL.org provides a multitude of resources concerning state implementation of the ACA. This webpage links to: [State Actions to Implement the American Health Benefit Exchange](#), [Affordable Care Act Grants Awarded to States](#), [Federal Health Reform: State Legislative Tracking Database](#), [2010 State Actions to Implement Federal Health Reform](#).

[Insurance Exchanges: Reports and Analysis](#), RWJF SCI

This section of StateCoverage.org provides a myriad of resources on insurance exchanges, including reports and analysis, resources from the states, resources from the federal government, and meetings and webinars.

[Medicare and Health Policy](#), *NASI*

This section of NASI.org provides various health policy briefs, several of which concern health insurance exchanges.

[State Based Health Insurance Exchanges](#), *National Governors Association (NGA)*

This section of NGA.org provides publications on exchanges produced by the NGA and NAIC as well as other general information concerning health reform.

[Tag: Exchanges](#), *Health Reform GPS*

This link takes you to all documents—including briefs, news, and third party resources—available on HealthReformGPS.org that are tagged with the term “exchanges.”