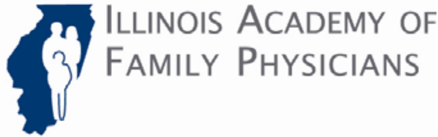

Written Statement/Testimony

TO: Legislative Study Committee

FROM: Illinois Academy of Family Physicians

RE: Health Benefits Exchange

DATE: August 30, 2011

IAFP is limiting its comments primarily to issues that are of particular importance to family physicians in their efforts to play a critical and **supportive** role in the implementation of health care coverage expansion and reform as provided in the Patient Protection and Affordable Care Act (ACA). The following review and principles best explain and support our focus on certain Exchange implementation and enforcement policies:

In weighing options to form an exchange, Illinois should adopt policies to:

- protect consumers
- improve quality of care provided
- decrease costs across the health care system.

A critical element to achieving such goals is primary care. Studies repeatedly demonstrate that a primary care-based system restrains cost increases, improves quality and increases patient satisfaction. Family physicians in Illinois believe an ideal insurance plan would offer benefits to patients and offer incentives for high value primary care.Primary care is proven to be the foundation of high-performing health systems, including WellMed (San Antonio, TX) Geisinger Health System (Danville, PA), and Group Health Cooperative (Seattle, WA)

To ensure exchanges utilize all primary care has to offer, family physicians encourage members of the Legislative Study Committee to consider the following principles in developing exchanges:

1. Fair Representation of Stakeholders
2. Payment for PCMH & Enhanced Access
3. Standardized Contracting
4. Set Primary Care Targets
5. Require Robust Primary Care-Based Essential Benefits
6. Presume Eligibility
7. Reward Quality
8. Protect Consumers & Physicians

1) FAIR REPRESENTATION OF STAKEHOLDERS: Health care touches everyone's lives – to that end, fair representation of stakeholders ensures that all voices are heard. Representation must be broad-based and include representatives of certain essential segments. The governing body of an exchange should include, by statute, at least one seat for consumers and at least one for primary care physicians, in at least equal proportion

to the total number of seats allotted to insurers, specialty medicine, health systems and other stakeholders. A board of directors should be appointed based on relevant expertise, representing a broad spectrum of interests.

2) PAYMENT FOR THE PATIENT-CENTERED MEDICAL HOME (PCMH) & ENHANCED ACCESS: Benefit design should incentivize primary care. Enhanced payment for PCMHs, care coordination, and enhanced access through e-visits, open scheduling and expanded hours should be considered as part of "qualified coverage" for plans wishing to participate.With new medical-loss ratio requirements and the likelihood of increased competition, insurers participating in the exchange will need to limit costs and encourage savings. Under section 1301, ACA allows qualified health plans to offer coverage through a primary care medical home, also known as a patient-centered medical home, a delivery model that is proven to reduce the frequency and length of emergency room visits and hospitalizations, restrain cost increases, and enhance the quality of care provided, particularly for those with chronic conditions. Our current payment system rewards providers for performing more services, not delivering better care. PCMH is proven to restrain costs and provide better care. Patients want enhanced access; primary care practices should be paid appropriately for providing these important services.

3) STANDARDIZED CONTRACTING: Physician contracting should be standardized across all plans in any exchange, just as enrollee applications are standardized. "All products clauses" must be prohibited. Clear and understandable contracts will help plans meet their requirement to have adequate networks of participating providers. Standardized contracting will help the market determine which plans attract the best physicians.

4) SET PRIMARY CARE TARGETS: Illinois'Exchange should set targets for primary care spending by participating plans. Primary care is undervalued in the current health care payment system. Setting targets for the amount medical spending plans dedicate to primary care will help begin the rebalancing. Rhode Island successfully implemented this strategy to temper the increase of premiums and other costs in the private market, while promoting a more efficient, PCMH- and primary care-oriented delivery system.

5) REQUIRE ROBUST PRIMARY CARE-BASED ESSENTIAL BENEFITS: Illinoisshould require health plans to offer primary care services beyond those required by the federal essential benefits regulation. An essential benefits package should include important front-end investments in patient health, including, but not limited to, no co-pay for out-of-network primary care services, low or no cost medications for patients with certain chronic diseases (asthma, for example) and incentives for patient engagement. Preventive care works. Primary care works.

6) PRESUME ELIGIBILITY: Enrollees should receive presumptive eligibility—or provisional enrollment—to allow for delivery of essential preventive and primary care services upon submission of an application. 16 states adopted this policy for Medicaid and/or CHIP applicants. Not only do disruptions in insurance coverage have adverse effects on access to care and administrative costs, problems can arise simply from changes in health plans, even without gaps in coverage. Combining presumptive eligibility for all plans, public and private, with the new first-dollar coverage for preventive services delivered by primary care physicians will help keep patients out of emergency rooms while controlling costs.

7) REWARD QUALITY: Providers should be rewarded for providing quality care. Quality measures should be aligned across plans in the exchange(s) and with the state's Medicaid, CHIP and state and local employee health benefits plans. Such measures also should coordinate with Medicare, when possible. Reporting to multiple payers on different measures creates an undue administrative burden on physician practices. 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.

8) PROTECT CONSUMERS & PHYSICIANS: While commonly referred to as the ACA, the first two letters commonly dropped off are "PP" – "Patient Protection" The law provides many new protections for patients and means of seeking redress and assistance. Family physicians, who frequently act as advocates for their patients, should have equal access to the services of programs designed to assist health care consumers. 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.

CONCLUSION:

The Illinois Academy of Family Physicians welcomes the opportunity to provide additional comments.We urge the Legislative Study Committee to consider these principles and policies as the establishment of an Illinois exchange is deliberated. Furthermore, we ask that the Legislative Study Committee reference these materials and resources as it conducts the study and reports its findings. Thank you.

For more information on the value of primary care, please visit our website www.iafp.com or contact: Gordana Krkic, CAE, Deputy Executive Vice President, at 630-427-8007.

Additional Sources:

Designing an Exchange: A Toolkit for State Policymakers, National Academy of Social Insurance (NASI)

Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues, The Commonwealth Fund

Insurance Exchanges under Health Reform: Six Design Issues for the States, Health Affairs

Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues, The Commonwealth Fund

The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned, Georgetown University Health Policy Institute Center for Children and Families (CCF)