Making the Marketplace More Patient Focused

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Back in June 2012, I wrote that a healthcare revolution was already under way in this country, and that there was no turning back.[1] The Affordable Care Act (ACA) is the law of the land and millions of people are reaping the benefits—no discrimination for preexisting conditions or gender, improved coverage for children and the poor, and changes in Medicare to better serve the elderly caught in the "donut hole," to name only a few of the monumental advancements to healthcare delivery.

As more and more people become aware of the ACA and see the law in action, we face a new opportunity this summer. This is an opportunity to make the law better and strengthen the health insurance marketplace.

The final rule on essential health benefits, actuarial value of qualified health plans (QHPs), and accreditation of issuers laid out the standards that are now in effect for calendar year 2014 and 2015.[2] This year, the Obama administration is expected to evaluate the current structure of the insurance marketplace and begin working on standards for 2016, which will be released in early 2015. This document will provide new guidance to QHPs to ensure continued access to affordable health coverage.

This year is the advantageous moment to build on the successes already achieved under the ACA and to enhance marketplace operations in a way to make them more patient focused. In particular, the patient advocacy community believes there are needed improvements in 5 core areas: nondiscrimination, transparency, uniformity, continuity of care, and enforcement (**Table**).

Nondiscrimination

The ACA took a groundbreaking step in healthcare delivery by outlawing QHPs from discriminating against people with preexisting conditions. But the guidelines need to be more specific to prevent any unintended restrictions on care for people with complex chronic conditions.

For example, out-of-pocket costs must not create a barrier to access. Even though there is an out-of-pocket maximum on individual healthcare costs, people with complex—and expensive—healthcare needs could conceivably face their $6350 limit in the first month of coverage.[3]

Benefit designs should not create discrimination caused by unfair plan design elements, including utilization management techniques, the structure of the formulary, and cost-sharing requirements. QHPs should also provide meaningful access to healthcare providers across various specialties.

Transparency

Purchasing health insurance can be a daunting task for people, and particularly for individuals who have never had to buy insurance before the ACA and its mandate for coverage were enacted. The only way patients will be able to make intelligent purchasing decisions is if they have access to complete details about the coverage and cost of QHPs offered in their state.

Information about plans should be designed in a way that leads to an understanding of the enrollee's options. The information should be accessible in a variety of ways so it may serve a diverse patient population, such as via print, Web, and mobile devices. Patients should have easy access to comprehensive details about each plan prior to enrollment. Easy-to-understand, easy-to-locate formularies and provider network lists should be required of all plans.

Uniformity

Hand-in-hand with meeting transparency requirements, QHPs also need to provide their information in a uniform manner to make it easier for patients to compare plans side-by-side. The federal government should develop and require QHPs to use a standard template for formularies and provider networks. There also needs to

Table. Principles for Modifications to Ensure a Patient-Focused Insurance Market

Principles	Values
1. Ensure that cost-sharing structures and other plan design elements do not discriminate against people with chronic conditions or impede access to care.	1. Minimum essential health benefit (EHB) requirements must not discriminate against people with chronic conditions. 2. Benefit designs must not create discrimination caused by unfair plan design elements, including utilization management techniques and the structure of the formulary (eg, use of specialty tiers) and cost-sharing requirements. 3. Qualified health plans (QHPs) must provide meaningful access to healthcare providers across various specialties to enrollees with complex healthcare needs. 4. Out-of-pocket costs must not create a barrier to access.
2. Create transparency standards to ensure patients have access to complete details about coverage and cost of health insurance exchange plans.	1. Patient information about plans should be designed in a way that leads to understanding of an enrollee's options. 2. Information should be accessible in a variety of ways to serve a diverse patient population (print, Web, mobile devices, etc). 3. Patients should have easy access to comprehensive details about each plan prior to enrollment. 4. Easy-to-understand, easy-to-locate formularies (including electronic versions) should be required of all plans. 5. Easy-to-understand, easy-to-locate provider network lists (including electronic versions) should be required of all plans.
3. Make insurance exchange plan materials easier for patients to understand by creating uniformity of content and design.	1. Plans should be presented in a way to make it easy for patients to conduct side-by-side comparisons. 2. Patients and healthcare providers should be able to easily navigate grievances and appeals processes. 3. Plan medical necessity determinations should be easy to understand.
4. Establish continuity of care requirements that protect patients transitioning into new coverage.	1. Patients should have the freedom to change plans during applicable enrollment periods without concern of encountering repeat barriers in a new plan. 2. QHPs must not create undue barriers for new enrollees transitioning from other plans.
5. Ensure that all health insurance exchange plans meet federal requirements.	1. Patients should be confident that nondiscrimination standards that meet a federally established threshold are uniform across the United States. 2. Baseline criteria for qualified health plans must be established and adhered to. 3. States must be held accountable for issuers out of compliance with federal and state policies.

be a uniform process that is clear and easy to navigate for people who need to file grievances with their plans or appeal adverse plan coverage determinations. These determinations should be easy for patients to understand and include a uniform definition of what services are deemed a "medical necessity."

Continuity of Care

As people with chronic conditions become savvier about purchasing health insurance, they will naturally consider changing their plans during an approved enrollment period in order to better meet their budget and health needs. They should have the freedom to transition to new plans, and to do so without encountering repeated barriers.

QHPs should be required to fill prescriptions for patients who are transitioning into the new plan and also stabilized on specific medications. Plans should honor any prior authorization, step therapy, or exceptions process already attained by an enrollee. Plans should also allow the transitioning patient to continue treatment for a set period of time under the care of a prior physician or specialist and receive care as if the provider is "in network."

Enforcement

With 16 states (and the District of Columbia) running their own insurance marketplaces, 15 others with various forms of federal-state arrangements, and 19 federally facilitated marketplaces, there are bound to be differences.[4] For the approximately 36 million people who relocate each year, these differences could be a rude awakening when they shop for a health plan in their new community.[5]

Patients should be confident that any QHP sold through the marketplace meets federally established nondiscrimination standards and that the threshold is uniform across the United States. There should be a federal monitoring program to ensure that appropriate quality checks are in place to guarantee that QHPs are meeting federal requirements and that states are held accountable for plans not in compliance.

Turning Principles Into Action

The patient advocacy community has created a list of basic principles that it believes should guide the federal government as it considers modifications to the insurance marketplace. In the coming months, all stakeholders in the health community—including insurance companies; provider organizations; and pharmaceutical, biotechnology, and medical device companies—will be invited to work with the National Health Council and its patient advocacy organization members to sketch out potential solutions. We believe that as long as the patient—especially the patient with complex chronic conditions—is at the focal point of the discussion, then the solutions will ensure a more robust and effective healthcare marketplace for all.

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REFERENCES

1. Weinberg M. Healthcare reform and the Supreme Court. *Am J Pharm Benefits.* 2012;4(3):118-119.

2. Patient Protection and Affordable Care Act: standards related to essential health benefits, actuarial value, and accreditation. US Department of Health and Human Services. Federal Register; Vol 78(37).

3. Department of Health and Human Services. Glossary: Out-of-pocket maximum/limit. Department of Health and Human Services website. https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/.

4. State Action to Establish Health Insurance Marketplaces. Commonwealth Fund website. http://www.commonwealthfund.org/Maps-and-Data/State-Exchange-Map.aspx. Published July 2013.

5. US Census Bureau. About 36 million Americans moved in the last year, Census Bureau reports. US Census Bureau website. http://www.census.gov/newsroom/releases/archives/mobility_of_the_population/cb13-192.html. Published November 18, 2013. ajpb