HEALTH INSURANCE EXCHANGE CONSUMER PRINCIPLES

The Affordable Care Act (ACA) mandates the establishment of a health insurance exchange in each state by January 1, 2014, to facilitate the purchase of health coverage by individuals and small businesses. As states implement their health insurance exchanges, the following principles should be incorporated to maximize consumer choice of meaningful health coverage:

Promote Choice and Competition: *Exchanges should enhance choice and affordability of health insurance coverage.*

- Consumers benefit when a broad selection of health plans compete on value and comprehensiveness of coverage. To foster plan competition, states should allow all plans that meet the ACA's minimum requirements for a qualified health plan, and any enhanced standards mandated by the state, to participate in the exchange.

Ensure Meaningful Coverage: *Exchanges must ensure meaningful coverage that provides comprehensive access to treatments for all consumers, especially those with chronic conditions or other complex needs.*

- Individual and small group plans sold in an exchange are among the plans required to comply with the ACA's essential benefits coverage requirements. In defining their essential benefits, states should select a benchmark plan that provides comprehensive prescription drug coverage and access to critical therapies.

- For example, the Federal Employees Health Benefits (FEHB) plan, a benchmark option states can select, covers all available drugs through its "open" formulary." Such broad access is critical to a plan's ability to provide high quality coordinated medical care and to reducing long term health costs by avoiding unnecessary hospitalizations and preventable medical care.

- To evaluate whether a plan's benefits are substantially equal to the state's benchmark plan, states should consider formulary breadth. For instance, if the benchmark plan provides coverage of three drugs in a therapeutic class, all individual and small group plans should be required to cover at least three drugs in that same class.

Guarantee Affordable Access: *Exchanges must protect consumers from discriminatory benefit designs that levy excessive cost-sharing requirements on the most vulnerable consumers.*

- States must vigorously uphold the ACA's prohibition of discriminatory plan designs within an exchange. This includes restricting plans from using specialty tiers that levy excessive cost-sharing requirements on vulnerable consumers with complex conditions and requiring "fail first" policies or step therapy programs to reflect guidelines from expert organizations and industry standards.

Provide Strong Consumer Protections: *Exchanges must safely transition consumers into and between coverage and provide an adequate process for appealing coverage denials.*

- State must guarantee consumers a safe transition into and between exchange plans by ensuring uninterrupted access to needed medications. At a minimum, states should require exchange plans to allow consumers, during the first 90 days of enrollment in a new exchange plan, to receive one 30-day supply of an ongoing prescription, even if that medicine is not on formulary or would otherwise be subject to utilization management (i.e. prior authorization or step therapy). A similar policy in Medicare Part D has successfully guaranteed uninterrupted access to needed medicines for millions of consumers.

- Consumers must also have an adequate process for appealing coverage denials. Specifically, exchanges should consider incorporating Medicare Part D standards with respect to grievances and appeals. This includes a 72-hour time limit for coverage determinations under a standard process and a 24-hour time limit under an expedited process for emergency situations.

- State definitions of “medical necessity” should be updated to defer to a physician’s reasonable determination that the treatment is in the best interest of the patient. Such a standard would ensure access to essential benefits is appropriately managed by a patient’s physician rather than a health plan.

Hold Plans Accountable: *Exchange plan ratings should incorporate patient-centered metrics that spotlight high-quality plan performance.*

- Under the ACA, exchanges must rate each plan offered on the basis of their relative quality and value. To assist patients in selecting high-quality coverage, plan ratings should, at minimum, incorporate factors such as: 1) affordability with respect to premiums, deductibles, and point-of-service cost-sharing; 2) enrollee satisfaction; 3) high standards for provider network adequacy; and 4) provider incentives for health homes or chronic care management or care coordination for enrollees with complex, high-cost, or multiple chronic conditions.