



ANA ISSUE BRIEF

*Information and analysis on topics affecting nurses,
the profession and health care.*

State Health Insurance Exchanges **The critical role of nurses & nursing**

Essential Health Benefits

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

What is an Exchange?

The Affordable Care Act (ACA) provides for development of State Health Insurance Exchanges. Exchanges will be portals where individuals and small businesses can buy affordable and qualified health benefit plans. They will be designed to enhance competition in the health insurance market, improve choice of affordable health insurance to individuals, and give small businesses the same purchasing clout as large businesses. The Exchanges are scheduled to start open enrollments in October 2013, for insurance effective dates beginning January 1, 2014. They will allow individuals and small employers to compare private health insurance options based on price and quality. The intent is to create a level playing field for insurers and consumers that will reduce health care costs and increase quality.

Each Exchange will receive information from health insurers and health plans that want to offer their services through the Exchange. They will determine whether the plans are qualified to participate in the Exchange. And they will provide this benefit and cost information to the individuals and small businesses that are eligible to purchase health coverage through the Exchange.

States have flexibility to design an Exchange or multiple Exchanges that meet the specific needs of the State's population and healthcare market. For example:

- ◆ States may create separate Exchanges for the individual and small business markets
- ◆ States may join with each other and create regional Exchanges
- ◆ States may divide their territory geographically and create subsidiary Exchanges
- ◆ States may elect to not manage their own exchange; in this case the federal government will construct and administer the Exchange for the State

Inside vs. Outside the Exchange:

The establishment of Health Exchanges provides a portal where consumers and small businesses can purchase health insurance “inside” the Exchange. Marketplaces for health insurance that already exist may continue, or new ones may also develop “outside” the Exchange.

The same health insurance plans may be available for consumers to purchase “inside” and “outside” the Exchange. The qualifying rules apply only to plans sold “inside” the Exchange. ACA subsidies are only available “inside.”



The ACA identifies essential functions of the Exchanges

Each Exchange must maintain an up-to-date website that provides standardized comparisons of all **qualified health plans** offered through the Exchange. The exchange will **qualify** plans on several dimensions, including network adequacy (see page 5 for more details) and provision of the **Essential Health Benefits Package** (see sidebar).

One of the ACA’s goal is to ensure that every American has health insurance coverage. The Essential Health Benefits provide the definition and measure of what health insurance means. All health insurance plans sold inside and outside the exchange must cover the Essential Health Benefits package. The law stipulates that the essential health benefits must be comparable to a typical employer provided plan and include at least the ten categories of services included in the Essential Health Benefits.

Each State will choose a **benchmark health plan** from a specific variety of health insurance plans available in their State. This benchmark health plan will determine the level of benefits in each category. All States must select a benchmark plan, even if they *do not establish their own exchange*. If a State does not select a benchmark plan, the default is the largest small group plan in the State. If any of the ten categories are missing from the benchmark plan, the State must add the category.

All health insurance plans sold inside the Exchange (see sidebar) must cover the minimum benefit provisions; the only difference between the plans is in the cost sharing between the enrollee and the insurer. This makes

Cost sharing levels –

Insurers contribute

60% of costs of EHBP for **Bronze** plans

70% of costs of EHBP for **Silver** plans

80% of costs of EHBP for **Gold** plans

90% of costs of EHBP for **Platinum** plans

comparison between plans transparent to the consumer. The Exchange will categorize the health insurance plans by levels of cost sharing: **Bronze, Silver, Gold, & Platinum** levels. Each insurer participating in the Exchange must offer at least one plan at the silver & gold levels.

The Exchange will offer transparency regarding the value the consumer receives through each health plan by providing premium costs, standardized actuarial rating (metal level), quality ratings as assigned by accreditation agencies, medical loss ratios (see box on page 3) and up-to-date provider directories.

ANA believes Exchanges must include:

- ◆ APRNs as primary care providers in qualified plans
- ◆ Nurse Managed Health Clinics, School-Based Health Clinics, and Free Standing Birth Centers as Essential Community Providers
- ◆ APRNs as team leaders in Patient Centered Medical Homes
- ◆ Nurses in the governing board of State Health Insurance Exchanges

Medical Loss Ratio (MLR)

The Affordable Care Act requires health insurance companies to spend a minimum percentage of the premiums they collect on health care services and quality improvement activities (versus what the company spends on administrative costs) for the people they insure. This percentage is called the medical loss ratio (MLR). For plans sold inside the Exchange to individuals and Small Business Groups, the MLR requirement is 80%.

Exchanges must provide **Consumer assistance tools**. There must be a toll-free call center that addresses the needs of consumers requiring assistance. The Exchange must provide the information to applicants and enrollees in plain language and in an accessible and timely manner for individuals living with disabilities including auxiliary aids and services at no cost to the individual. This includes interpretive services for people who have limited English proficiency.

Each Exchange will provide **navigators**, who are experts in consumer eligibility, enrollment processes, and plan benefits and have cultural and language expertise consistent with the needs of the population served. These navigators will help to: 1) facilitate users to select a health plan; 2) conduct public education activities to raise

awareness about the Exchange; and 3) refer complaints or problems to appropriate agencies for resolution.

The Exchange must offer a **seamless streamlined process** to determine consumer eligibility for Medicaid or CHIP benefits and tax credits or premium subsidies (cost-sharing reductions) for private health insurance plans.

States have the option of creating a separate Exchange for the **Small Business Health Options Program (SHOP)** or incorporating the small business purchasers into the individual market Exchange. The SHOP program provides insurance options and large group purchasing clout to small employers enabling them to offer health insurance plans to their employees.

ANA Advocacy

In response to the [proposed federal rules governing State Health Exchanges](#), the ANA advocated through our [comments](#) for four foundational principles (see sidebar, this page) that will enable each Exchange to be responsive to nurse provider concerns and for the Exchange to foster improved access to primary care and health care cost reduction that is the intent of the health reform law.

[ANA analyzed](#) the [Interim Final Rule](#) in relation to our recommendations. Rather than instituting rules on a national basis regarding the ANA's area of [comments](#),



All four APRN roles provide some of essential health benefits required by qualified health plans.

All four APRN roles need to be included in health Exchanges.

Outdated policies that miss the mark by excluding nurse-provided clinical care from reimbursement are not based on evidence.

Check the status of the health Exchange in your State at HealthInsurance.org or the [Kaiser Family Foundation](http://KaiserFamilyFoundation.org).



the Federal government is allowing maximum flexibility to the States to incorporate these principles (and others) as each State establishes an exchange to meet the needs of its population.

Progress on Development of Exchanges

As of April 2012, only 15 States have authorized establishment of a State health exchange. Many others are in exploratory stages; several have indicated they will take no action while awaiting the outcome of the constitutional challenge to the ACA (that was decided June 28, 2012 by the U.S. Supreme Court). Two States (Arkansas & Louisiana) have ceded the authority for an exchange to the federal government. In any State that does not demonstrate readiness to operate an Exchange by January 2013, the federal government may administer the Exchange or share administrative duties with the State. Up to date status about each State's progress on Exchange establishment is available from several sources, including the consumer advocacy group, HealthInsurance.org and from a non-partisan health policy research foundation the [Kaiser Family Foundation](http://KaiserFamilyFoundation.org). See the resource list at the end of this brief for other sources.

Nurses and State Associations should Influence State Exchange Structure and Policy to promote quality and access to care

The result of 51 (including the District of Columbia) different exchanges with unique structures yet to be determined provides tremendous opportunity for nurses and nursing organizations to promote access to primary care and nurse-directed models of care.

State nurses associations can be active stakeholders to influence health care delivery through the Exchanges at the State level. These associations need to provide leadership and evidence to State Exchange Boards and Insurance Commissions about cost savings, improved access, and quality outcomes that studies repeatedly show occur through APRN-directed care.^{1-3 4} Additionally, in States where federally operated exchanges are possible, State associations and individual nurses should reach out to the federal [Center for Consumer Information and Insurance Oversight \(CCIIO\)](http://CenterforConsumerInformationandInsuranceOversight(CCIIO)) at CMS in addition to their State Insurance Commissioner. Coordination of efforts on this front from multiple State associations may be advisable.

The list of “**essential community providers**” must include *nurse-managed health centers, school-based health centers, and freestanding birth centers.*

The strategies of using the “any willing provider” or “any willing class of provider” laws have proven ineffective.



Include APRNs in Health Plans inside the Exchanges

All four APRN roles provide some of the essential health benefits required by qualified health plans. Examples include: **Nurse Practitioners** and **Certified Nurse-Midwives** provide primary ambulatory patient services that are included among essential health benefits. **Certified Nurse-Midwives** also provide maternity and newborn care that are essential health benefits. **Certified Registered Nurse Anesthetists** provide services through hospitalization, ambulatory services, and chronic disease management that are essential health benefits. **Clinical Nurse Specialists** are critical in the coordination of care for many of the essential health benefits like mental health and substance use disorder services and chronic disease management. All four APRN roles need to be included in health Exchanges. Outdated policies that miss the mark by excluding nurse-provided clinical care from reimbursement are not based on evidence. With support and advocacy at the State levels, these discriminatory reimbursement practices can be ended.⁴

Qualifying plans through network adequacy and essential community providers.

The ANA advocated that “**Network adequacy standards**” should include the requirement that insurance plans include APRNs as providers. The experience of Massachusetts (see sidebar, next page) demonstrates that without expanding the primary care network as millions of Americans gain new access to health insurance, access to care will not be improved. The

Network Adequacy

Arrangements that offer a sufficient choice of providers in-network and out-of-network while assuring reasonable access to quality primary and specialty care. The National Association of Insurance Commissioners (NAIC) Model Act for network adequacy includes all types of licensed health care professionals, including APRNs. CMS affirms the network must assure that all services will be available without unreasonable delay.

efficient and quality care demonstrated through APRN provided primary care¹⁻⁵ will help States, small businesses, and individuals actualize the cost-savings and improved access intended by the ACA. The establishment of State Insurance Exchanges provides an opportunity to end anti-competitive practices that have limited consumers’ access to their choice of providers by limiting types of providers with which a health plan is willing to contract.

Tales from Massachusetts – where reform has already occurred

The 2006 health reform in Massachusetts expanded health insurance coverage to most State residents, much as the ACA will do nationally in 2014. Massachusetts, experienced a significant shortfall in its primary care workforce that did not effectively meet the new demand. This resulted in increased average wait times for new patients to make first appointments from 17 days in 2005, reaching 31 days in 2008. This experience demonstrates that each State will need to expand their primary care workforce to meet new demand for services. APRNs can be ready to accept primary care patient assignments for newly insured clients.^{2,5} On the other hand, where nurse practitioners were available to assume the role of primary care providers, Massachusetts achieved significant cost savings in the first year. A RAND study, projects that substituting NP visits for physician visits will save the State \$4.2–\$8.4 billion (0.6–1.3 percent) for the period 2010–2020. Other States can also reap significant savings by incorporating APRNs as a cornerstone of their primary care workforce.³



The list of “**essential community providers**” must include nurse-managed health centers, school-based health centers, and freestanding birth centers. Nurse-managed health centers have long provided primary care to diverse

Essential Community Providers
Essential community providers that serve predominantly low-income, medically underserved individuals. They are to be included in qualified plan networks as long as the provider accepts the generally applicable payment rates of the plan.

populations, including those in need of a safety net.⁴ These nurse-directed models of care arise from the community and increase access to patient-centered quality care.⁴ The State Exchanges must support the value of nurse providers by inclusive contracting to improve access and quality of primary care by including Nurse-Managed Health Centers, School-based Health Centers, and Free

-Standing Birth Centers as essential community providers.⁴

Currently, with some private insurers, APRNs often face hours of bureaucratic hindrances to being listed within **provider directories** and websites. Provider Directories should list *all* credentialed providers in the online version, print versions, and call center staff must be aware of how to connect consumers with the provider of their choice.

Any Willing Provider Laws

The strategies of using the “any willing provider” or “any willing class of provider” laws have proven ineffective in advancing this cause. The 23 States that have such laws have demonstrated little encouragement for managed care credentialing policies regarding APRN primary care providers.^{1,6} The most recent study of its type, revealed in 2009 that nearly half (48%) of managed-care organizations did not credential nurse practitioners as primary care providers.⁶ State health exchanges offer opportunities to remedy this blatant discrimination.

Nurses and State associations will need to not only monitor but also participate in the development of Exchanges in their States to deliver the evidence of quality, improved access and cost saving available through APRN directed primary care.

States have flexibility to design an Exchange or multiple Exchanges that meet the specific needs of the State's population and healthcare market.

Stories from the States

It may be helpful to learn how the States that have significant progress towards exchange establishment have accomplished or plan to accomplish inclusion of nurse-directed care through the models specified above.

ANA/**California** keeps up-to-date information about the status and activities of the California Health Care Benefit Exchange Information on the [Health Reform page of their website](#), providing transparency and notice when Exchange Board is soliciting public comments. State associations and nurses should monitor this progress closely to ensure inclusion of the principles of nurse-managed primary care for insurance plan qualification.

Nine voting and three ex-officio board members govern the [Colorado Health Benefit Exchange](#). One of the ex officio members in Colorado is a nurse, though the authorizing legislation does not specify that a nurse be included. The Colorado Nurses Association (CNA) worked early in the process with State coalitions and advocacies groups to influence the legislation and promote representation of consumers and providers on the Exchange board and to endorse inclusion of APRNs in network adequacy standards. They also testified at a State legislative hearing to promote consumer and provider representation. The CNA plans to monitor continuing legislation. The Colorado Exchange Board is beginning to discuss Advisory Groups for the exchange and has solicited public comment. Nurses and nursing organizations have opportunity to shape the makeup of these groups, thereby impacting the way health plans are selected and qualified for the Exchange.

In **Mississippi** the existing independent, not-for-profit, high-risk pool program, the [Mississippi Comprehensive Health Insurance Risk Pool Association](#), will establish the State's health insurance exchange and be regulated by the State Insurance Department. The Mississippi Nurse's Association (MNA) has three nurses serving the health providers subcommittee that makes recommendations on the essential health benefits provisions to the Advisory Committee. A representative from the MNA attends the monthly advisory committee meetings.



Nurses and State associations will need to monitor the development of Exchanges in their States to deliver the evidence of quality, improved access, and cost saving available through APRN directed primary care

Vermont has an established a [Health Benefits Exchange Board](#) that includes a nurse practitioner on the executive committee. Vermont is structuring its Health Exchange to be a platform for the State's single-payer health system projected to be implemented in 2017. Nurses should watch the progress here closely to ensure equity of provider credentialing and access for the community as this innovative model or payment is designed.

Resources for monitoring the status of the Exchange in your State–

The original [federal notice of proposed rule-making about State Health Exchanges](#) was published July 15, 2011.

[ANA analyzed](#) the interim final rule to compare the recommendations from [our comments](#) with the actual rule.

The [Interim Final Rule](#) about State Health Exchanges was published in the Federal Register on March 27, 2012

Additional resources

[HealthInsurance.org](#) is a consumer advocacy organization that presents and interactive tool with updated status of State Health Exchanges in each State in simple terms, directed at consumers.

[Kaiser Family Foundation](#) is an independent, private, non-profit foundation that conducts research and policy analysis on major health issues in the United States. Their website offers and interactive tool to monitor status of Health Exchanges in all States <http://www.ncsl.org/issues-research/health/State-actions-to-implement-the-health-benefit-exch.aspx>

The [National Conference of State Legislatures](#) (NCSL) is a bipartisan organization that serves the legislators and staffs of the nation's 50 States, its commonwealths and territories. Their interactive tool provides the level of detail that State legislators and policy-makers need to keep abreast of the status of Health Exchanges in all States.

The [National Association of Insurance Commissioners](#) offers in-depth information about calculating the Medical Loss Ratio

[Center for Consumer Information and Insurance Oversight](#) (CCIIO) is the division of CMS that proposes and implements rules and guidance for the State Health Insurance Exchanges <http://cciio.cms.gov/programs/exchanges/index.html>



References

1. Chapman SA, Wides CD, Spetz J. Payment regulations for advanced practice nurses: Implications for primary care. *Policy, Politics, & Nursing Practice*. 2010 May 01;11(2):89-98.
2. Jacobson P, Jazowski S. Physicians, the Affordable Care Act, and primary care: Disruptive change or business as usual? *Journal of General Internal Medicine*. 2011;26(8):934-7.
3. Naylor MD, Kurtzman ET. The role of nurse practitioners in reinventing primary care. *Health Affairs*. 2010 05;29(5):893-9.
4. Pohl J, M., Tanner C, Pilon B, et al. Comparison of nurse managed health centers with federally qualified health centers as safety net providers. *Policy, Politics, & Nursing Practice* 2011 05;12(2):90-9.
5. Bodenheimer T FAU - Pham, Hoangmai,H., Pham HH. Primary care: Current problems and proposed solutions. *Health affairs (Project Hope) JID - 8303128*. 0504.
6. Hansen-Turton T, Ritter A, Torgan R. Insurers' contracting policies on nurse practitioners as primary care providers. *Policy, Politics, & Nursing Practice*. 2008 November 01;9(4):241-8.

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