NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

Guide to State Health Insurance Exchanges

Critical Facts and Issues for Pharmacy Associations/Advocates

Critical Background

The Affordable Care Act (ACA) requires each state to create a new, government subsidized marketplace in which residents may purchase health insurance. This new marketplace is called an exchange and the newly enacted law requires two types of exchanges: American Health Benefit Exchanges for Individuals (AHB) and Small Business Health Options Program (SHOP) Exchanges for small employers. A health insurance exchange can be available to all or can be limited to those without access to employer sponsored health insurance such as the self-employed, small business employees or those who do not qualify for Medicaid. The individual states will establish and regulate their own exchanges—unless they opt to let the federal government do so for them—and they have the option to merge both exchanges into one or to partner with other state exchanges. Section 1311 of the Affordable Care Act requires the formation of these exchanges by 2014 and HHS will determine by January 2013 whether an individual state has taken the actions necessary to implement an exchange.

Necessary State Determinations Regarding Structure/Role of the Exchange

Under federal law, states have the option of establishing the exchange as part of an existing state agency or office, as an independent public agency (quasi-governmental) or as a non-profit entity. States also have flexibility in determining the role of the exchange with respect to contracting with health plans; however exchanges may only contract with health plans that meet minimum federal requirements for qualified health plans including the proviso that they must cover essential health benefits. Any state exchange must also work in concert with the state insurance commissioner and existing insurance regulations.

State Activity to Date—January 2012

As of January 2012, fourteen states have established an exchange either through legislative efforts (13 states) or through Executive Order (1 state); five states plan to establish an exchange; two states are considering pending legislation to establish an exchange; twenty-two states are studying various options; six states have indicated no significant activity to date and two states have definitively determined that they will not establish an exchange (Arkansas and Louisiana). Those states that have not taken any definitive action to date must do so in 2012 in order to avoid federal intervention and this issue is expected to be hotly debated in 2012 state legislative sessions.

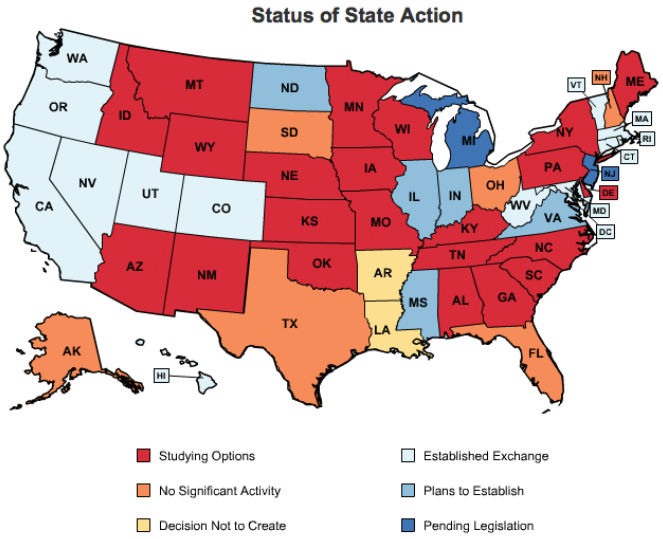
Essentially, there are three basic exchange "models."

- Market Organizer—Under this model, the exchange can contract with all qualified health plans and the exchange serves as an information source for consumers—providing them with the necessary information to make comparisons
- Selective Contracting Model—Under this model, the state plays a more active role and chooses to contract with a limited number of health plans that meet certain cost or quality metrics
- Active Purchaser Model—Under this model, the state actually purchases health insurance on behalf of consumers

In addition to choosing the exchange "model" and governance structure, states must also determine: how the exchange will operate within the existing state commercial insurance market; the interaction/eligibility processes that must be coordinated between any state exchange and the state Medicaid and CHIP programs; and the state must choose a "benchmark" plan that will define what constitutes "essential health benefits."

- State Pharmacy Associations/advocates may wish to advocate for a "selective contracting model" in which the state contracts only with those health plans that provide additional transparency and accountability of their PBM over and above the minimum disclosures required under federal law/

proposed regulation and those health plans that include independent pharmacies in their comprehensive pharmacy networks.



State Determination of a "Benchmark Plan" to Establish Essential Health Benefits (EHB) in Qualified Health Plans Sold by State Exchanges

Under federal health care reform, starting on January 1, 2014, qualified health plans sold in health insurance exchanges must cover all essential benefits. In addition, new plans sold in the individual and small group markets must cover essential benefits, regardless of whether plans are sold inside or outside of state health insurance exchanges. Section 1302(b)(1) of ACA already establishes that essential health benefits must cover ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health services (6) **prescription drugs**; (7) rehabilitative and habilitative services; (8) laboratory services; (9) **preventative and wellness services and chronic disease management**; and (10) pediatric services. Section 1302(b)(2) of the ACA also provides that the EHB shall equal the scope of benefits provided under a typical employer plan.

On December 16, 2011, the Center for Consumer Information and Insurance Oversight (CCIIO) issued an Essential Health Benefits Bulletin designed to provide further guidance as to what constitutes essential health benefits under ACA.

This most recent guidance documents provides that EHB will be defined by a "benchmark" plan selected by the state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" as required by ACA. CCIIO has determined that there are essentially four benchmark plan types that best reflect the statutory standards for EHB under the ACA.

These four benchmark plan types are:

1. The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market
2. Any of the largest state employee health benefit plans by enrollment
3. Any of the largest three national FEHBP plan options by enrollment
4. The largest insured commercial non-Medicaid HMO operating in the state

States are permitted to select a single benchmark to serve as the standard for qualified health plans inside the Exchange operating in their state and plans offered in the individual and small group markets in their state. If a state does not select a benchmark plan, the default benchmark for that state would be the largest plan by enrollment in the largest product in the states small group market.

Federal Guidance to Date Regarding Pharmacy Benefits

CCIIO provides that in order to ensure competition within pharmacy benefits, they plan to propose a standard for the state exchanges that reflects the flexibility permitted in Medicare Part D in which plans must cover the categories and classes set forth in the benchmark, but may choose the specific drugs that are covered within categories and classes. If a benchmark plan offers a drug in a certain category or class, all plans must offer at least one drug in that same category or class, even though the specific drugs on the formulary may vary.

Independent Pharmacy Priorities and Concerns Regarding the Selection of a "Benchmark Plan"—Prescription Drugs and Preventative and Wellness Services/Chronic Disease Management

Because of the fact that the details surrounding the ten categories of essential benefits (as identified in federal health care reform) will be determined at the state level—it is critical that state pharmacy associations and active practitioners make their voice heard to ensure that state benchmark plans take into account the following factors:

1. **Any state benchmark health plan should ensure that all patients have the option to receive prescription drugs from their community pharmacy—and should not mandate the use of mail order pharmacy.**

   It is important to note that that access to prescription medication should NOT be equated with access to prescription medication only via mail order pharmacy services. State policymakers must be educated that while there seems to be a prevalent misconception that mail order pharmacy is a tested technique that has been used to drive down costs,—this is simply not true.

   Mail order pharmacy services are simply not appropriate for all patients or medical conditions. For example, mail order pharmacy is not appropriate for populations such as the elderly or those with multiple chronic conditions or for those medications that are temperature sensitive or designed to treat acute conditions.

2. **Any state benchmark health plan should recognize pharmacists as accepted providers of preventative/wellness services.**

   Just as the practice of medicine has undergone a change in focus from the treatment of disease states to preventative care, pharmacy has gone from an emphasis on medication dispensing to one of effective medication use and achieving optimal patient outcomes. Community pharmacies represent the most accessible point in patient-centered health care with 92% of Americans located within five miles of a retail pharmacy. Typically, consumers do not need an appointment to talk with a pharmacist in a community pharmacy about prescription medications, over-the-counter products or any other health-related concern.

   Today, pharmacists routinely provide a wide array of preventative services for patients, including blood pressure and cholesterol screening, tobacco cessation and obesity-related counseling and intervention as well as routine immunizations. Pharmacists are now authorized to administer most routine immunizations based on various criteria in all fifty states. Many Medicare beneficiaries currently receive their annual flu and pneumonia vaccinations each year from a pharmacist. These are covered under Medicare Part B while other vaccinations provided by pharmacists are reimbursed under Part D.

3. **Any state benchmark plan should include pharmacist-provided medication therapy management (mtm) under chronic disease management.**

   The New England Healthcare Institute (NEHI) has estimated that medication-related problems including poor adherence impose as much as $290 billion in annual costs, or 14% of healthcare expenditures. These costs include emergency room visits, hospitalizations and other preventable forms of care. Pharmacist-provided MTM can prevent many of these adverse effects and ensure that patients with chronic conditions remain adherent to their recommended drug regimens.

   Pharmacists are currently providing MTM to patients in all care settings, as part of a team-based approach to care, as advocated by the Institute of Medicine. Pharmacists are successfully delivering MTM through state-based Medicaid programs, Medicare Part D programs, self-insured employers, and other private sector groups. These programs provide tangible examples of pharmacists providing MTM to improve lives and reduce the costs associated with patients with chronic conditions.

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Attachments:

- American Health Benefit Exchange Model Act (Model exchange act developed by the National Association of Insurance Commissioners)
- NCPA Model State Exchange Act (Provides suggested pharmacy-related additions to the NAIC model act)
- NCPA Comments submitted to HHS on proposed federal exchange regulations
- NCPA Letter to Institute of Medicine (IOM) on suggested inclusions to definition of essential health benefits (EHB)