The New Exchanges - Threat or Opportunity for the Physician

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Foster Swift Health Care Law Report
September 2010

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PRACTICE AREAS
Health Care

A core goal of the Patient Protection and Affordable Care Act (PPACA or Act) will be to reduce costs and improve quality. Sound familiar? It should. The 1980 Michigan Blues Reform Act's stated goals were to address cost, quality and access in the delivery of health care services under the aegis of the Michigan Insurance Commissioner.

Now, the attainment of these goals is to be the primary focus of so-called state sponsored "Exchanges" administered by a state government agency or non-profit organization. These Exchanges will be authorized to approve qualified health plans ("QHP") through which individuals and small businesses (up to 100 employees) can obtain health insurance. The Act provides for the Exchanges to award grants to so-called "Navigators", such as consumer groups, trade and professional associations and others who will carry out a broad litany of educational activities and services to the public regarding QHPs. Health insurance issuers are excluded from serving as Navigators.

Confronted by the new Exchanges and the QHPs, what is the role of the physician between these two giants?

It may be anticipated many of the kinds of problems physicians have encountered in the past in dealing with large super-entities will reemerge under the new law. The Act encourages the establishment and operation of non profit, member run health insurance issuers known as "Co-ops". Tucked in the Co-op section of the Act is a provision indicating that "Nothing in this section shall be construed as authorizing the Secretary (HHS) to interfere with the competitive nature of providing health benefits through qualified non-profit health insurance issuers."

Physicians should be concerned about: (1) arbitrary exclusion of physicians from panel participation; (2) fair, reasonable and defined appeals processes; and, (3) active physician involvement in the development and application of process and outcome measures (quality of care) among others. Since the exchanges are closely attendant to the regulation of qualified health plans, the providers must be wary of

undue coziness developing between the two giants. But with this must come physician assurance that they will not condone overutilization and the delivery of unnecessary services. At the same time, the elimination or failure to perform necessary services must also be looked at more closely. Mechanisms for cost control must not be allowed to slight quality of care and the performance of needed services for beneficiaries. A reasonable balance must be arrived at in the development of the new national quality improvement strategy.

Networks are called for to coordinate and deliver health care services for the uninsured and the underinsured. If we form responsible physician networks to deliver quality services, what fraud and abuse statutes will be implicated that bar constructive network development? Experience has taught us the answer to many of these questions. Waste has often been fostered by the government and third party payors, themselves, by impeding what can be constructive physician networks. There is no doubt that some physician excess has fostered some of the constraints doctors have contended with in the past. This whole area needs objective reexamination. We must think through more deeply than ever before about the direction of the new Act's provisions. Coordination, collaboration, and cooperation are imperative factors in realizing the full meaning of the new Act.

The new Act brings new opportunities for physicians as well as the state Exchanges and qualified health plans. This can be a good beginning for physicians if they don't slumber at the switch.