Consumer-Purchaser
DISCLOSURE PROJECT
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October 31, 2011

Donald Berwick, MD, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

File code: **CMS-9989-P**

RE: **Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans**

Dear Dr. Berwick:

The 23 undersigned organizations represent a collaboration of leading consumer, labor, and employer organizations, committed to improving quality and affordability of health care through the use of performance information to inform consumer choice, payment and quality improvement. We appreciate the opportunity to comment on the proposed rule pertaining to the establishment of Health Insurance Exchanges ("exchanges") and Qualified Health Plans, as mandated by the Patient Protection and Affordable Care Act (ACA).

While the primary goal of the exchanges is to organize access to insurance coverage for the millions of Americans who need affordable coverage, the development of these exchanges – both the federally-operated exchange and the individual state exchanges – provide a unique and critical opportunity to address the significant quality and affordability gaps that exist in today's health care delivery system. We hope that states and the federal government will recognize the potential for exchanges to serve as transformational tools, and design their exchanges in a way that drives improvements in quality of care, to further increase affordability across the entire system. To do so, exchanges must provide consumers with robust information on quality and cost of care, and they must include strong consumer and purchaser representation on governance bodies.

We envision a future in which exchanges activate consumers to make decisions based on quality and value. Many consumers are not aware of the variations in quality of care experienced in our current system, and the concept of quality does not intuitively link to the challenges and problems consumers face when navigating a fragmented health care system. Without this information, or understanding of the role they can plan in helping to improve the system, consumers may rely simply on cost comparisons to make their health plan decisions. By providing clear information on the importance of quality to both the individual's care and to the system, exchanges can play a role in improving quality and reducing costs across the board, contributing to the overall system transformation that the Affordable Care Act and other programs and initiatives were designed to achieve.

In order for exchanges to reach this potential, they will need to be designed with transformational goals in mind. Certain strategies, such as value-based competition among health plans and their affiliated providers, are not only foundational to driving such change, but are critical to establishing the type of healthy insurance market that is necessary for exchanges' sustainability. Value-based competition requires full transparency of quality and cost information, at both the health plan and provider levels, using evidence-based, consumer-friendly quality metrics that support accountability. Exchanges should also adopt other strategies used by private sector purchasers to drive quality and move the needle on costs, such as 1) using tools proven improvement tools such as the eValue8 survey to assess health plan

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performance; and, 2) using consumer-focused criteria to determine which health plans with which to contract. In addition, Exchanges should retain the authority to negotiate premiums in areas where there is not a viable competitive market, as long as this does not duplicate the actions of other state agencies. These strategies reflect practices used by large employers, and we believe that exchanges should have these and other options available in order to both leverage, as well as align with, the purchasing strategies of large employers, Medicare and Medicaid in ways that reflect the prioritization of quality and value.. Finally, a viable and healthy market will need policies in place to monitor, address, and mitigate the effects of adverse selection if and when it occurs.

The detailed comments that follow this letter reflect our vision of the urgent need for exchanges to be designed to meet the needs of their beneficiaries: individual consumers, small employers, and their employees. For consumers, this includes providing useful information on quality, access, and affordability, as well as easy-to-use decision support tools. For small employers, this means providing a reasonable number of plan and product choices, and offering premium aggregation, simplified billing and enrollment, and other business services to make participation as easy and attractive as possible. And in the future, for large employers this means establishing national standards and uniform processes for eligibility and enrollment, premium billing and payment, etc., to ease participation by multi-state employers.

The consumer and purchaser communities are eager to see states succeed at launching their exchanges on January 1, 2014, and recognize the myriad challenges they face in this endeavor. We welcome the opportunity to discuss our specific comments, and how they can be operationalized in a way that is feasible for states to pursue. The attached addendum outlines in more detail our specific comments on the sections of the proposed rule that relate to the following:

- Entities entitled to carry out exchange functions
- Functions of an exchange
- Consumer assistance tools and the Navigator program
- SHOP exchanges
- Requirements for Qualified Health Plans
- Network adequacy standards
- Treatment of Direct Primary Care Medical Homes
- Accreditation of QHP Issuers

On behalf of the millions of Americans represented by the undersigned organizations, we appreciate the opportunity to provide comments on the proposed Health Insurance Exchange regulations. If you have any questions, please contact either of the Consumer-Purchaser Disclosure Project's co-chairs, Debra L. Ness, President of the National Partnership for Women & Families, or Bill Kramer, Executive Director for National Health Policy at the Pacific Business Group on Health.

Sincerely,

American Hospice Foundation
Center for Study of Services
Childbirth Connection
Dallas-Fort Worth Business Group on Health
Employers' Coalition on Health
Employers Health Purchasing Corporation
The Empowered Patient Coalition
Healthcare 21 Business Coalition
Health Action Council Ohio
Health Policy Council of Iowa
Iowa Health Business Alliance
Massachusetts Group Insurance Commission
Mid-Atlantic Business Group on Health

Midwest Business Group on Health
National Business Coalition on Health
National Partnership for Women & Families
New Jersey Health Care Quality Institute
Northeast Business Group on Health
Pacific Business Group on Health
St. Louis Area Business Health Coalition
South Carolina Business Coalition on Health
Texas Business Group on Health
The Leapfrog Group

ADDENDUM
DETAILED COMMENTS ON *PROVISIONS OF THE PROPOSED REGULATION, PARTS 155-156*

PART 155: EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE ACA

Subpart B: General Standards Related to the Establishment of an Exchange by a State

Entities Eligible to Carry Out Exchange Functions
The core role of the exchanges is to ensure that consumers have access to high quality, affordable health insurance. The responsibility of achieving this vision will fall to the governance board, which should be made up of consumer and purchaser representatives and whose members must demonstrate no conflicts of interest related to the business of the exchange itself. We believe that HHS should explicitly outline transparency requirements for states that include conflict of interest requirements for entities contracted to perform functions that are the responsibility of the Exchange. These conflict of interest policies will in turn serve to build public confidence and trust in the exchanges, provide a set of ethical standards, and are simply sound business practice.

In states that choose to allow other stakeholders on the governance board, the majority of the board should remain comprised of consumers, consumer advocates, and purchasers to protect against erosion of consumer and employer confidence in the exchanges. All those who serve on the governance board must be subject to providing a complete, detailed accounting of potential conflicts of interest, including full financial disclosure. Members of the governing board should not have a direct financial interest in Board decisions or in any way benefit financially from selling items or services of significant value to the Exchange. Consumers and employers whose sole interest is to purchase health coverage through the Exchange should not fall into this category or be considered as having a conflicting financial interest. At a minimum, the proposed standard for implementing procedures for disclosure of financial interest by members of the Exchange board or governance structure should require that those with a financial interest in a matter before the Exchange be required to remove themselves from the discussion and voting on such matters. Two models to which HHS can look to for how this type of disclosure currently operates in practice are MedPAC and the Patient-Centered Outcomes Research Institute (PCORI) boards. Finally, states should be required to explicitly show how they are satisfying these transparency and disclosure requirements.

The director or chair of the governing board must – in addition to meeting ethical, conflict of interest, and disclosure standards – be able to demonstrate the ability to act in the best interest of consumers; monitor the composition of the exchange's governing board, and oversee the implementation and enforcement of conflict of interest policies.

In terms of defining a "consumer" governing board member, we recognize consumers to be individuals who have significant personal experience interacting with commercial health insurance and/or public programs, either as patients, family caregivers, or both. Consumers can draw on their experiences to help the exchange meet the needs of their consumer constituents. A "consumer advocate" governing board member is an individual who typically works for a non-profit, mission-oriented organization that represents a specific constituency of consumers or patients. Unlike other stakeholders, consumer advocates do not derive their livelihoods from the health care system and their primary emphasis is on the needs and interests of consumers and patients. Similarly, we define a "purchaser" governing board member as a representative of an employer and/or labor union, including current or former benefits directors, with experience in the complexities related to health coverage purchasing processes, training and expertise in the selection, purchase, and oversight of health plans, and ability to advocate on behalf of the needs of employees and small business owners.

In order to be productive contributors to such an entity, consumers, consumer advocates and purchasers may need assistance and support (e.g. mentorship, processes that facilitate their active participation, etc.). There are a number of states with experience in providing the type of support and education that

may be needed, and HHS should look to those states for models and provide guidance in the final rule on how state exchanges can implement these types of support.

Finally, in the event that conflict of interest and transparency policies may prevent insurer and broker representatives from potentially serving on governance committees, we suggest the governance board create a technical advisory panel to ensure that those with expertise in the administration of insurance in the individual and small group markets are able to advise the exchanges in their operational needs.

Stakeholder Consultation
The proposed rule states that consultation with multiple stakeholders should be sought by states in the development of exchanges. We strongly suggest that the final rule specify that this consultation occur as early in the design process as possible, to ensure that the views and concerns of consumers and purchasers are represented in the final policies. We also urge that the list of stakeholders includes organizations that may serve in the Navigator program, as well as non-profit, low-income taxpayer assistance programs. It should also be understood that having consumers, consumer advocates and purchasers on the governing board does not take the place of the establishment of strong partnerships with community-based organizations, consumer groups or employers. All are equally important to developing exchanges that meet the goals set out by the ACA.

Subpart C: General Functions of an Exchange

Functions of an Exchange
In addition to the myriad processes and functions related to eligibility, tax credit determination, enrollment, and overall administration of the exchanges, we firmly believe that exchanges must establish a comprehensive set of metrics for identifying how well they are performing at the critical operations of assisting consumers and getting them into the correct program with any appropriate subsidies. While this may fall into the category of "customer satisfaction," as per the language used in the proposed rule, we strongly urge substituting the term "customer experience" since the word "satisfaction" tends to skew results toward a favorable evaluation rather than the more neutral prompt that encourages consumers to describe their experience. Using the term "consumer experience survey" will also put this type of data collection on a parallel plane with the patient experience of quality of care data collection, which we call for in the following section on exchanges' quality initiatives.

The metrics collected to understand consumer experience should specifically target performance on the following: accuracy of eligibility and tax credit determinations; whether assistance (via call centers, the web portal, the Navigator program, or in-person) is being provided in an accurate, timely, effective, easy-to-access manner, and demonstrates responsiveness to concerns; evidence of bias in communications; and the effectiveness of the appeals process (both insurance coverage appeals and eligibility determination appeals). Metrics should also be created to collect data on consumers' use of various "doorways" in order to track where consumers are primarily going for information, which of those doorways may require additional resources; and finally, whether marketing and outreach efforts are achieving the goal of helping the exchange reach the right consumers. This data collection effort could be accomplished via a semi-annual consumer experience survey that would be available and conducted in multiple settings, to catch consumers through whichever doorway they use to make contact with the exchange.

Quality Initiatives as a Function of the Exchanges
The preamble to the proposed rule notes that HHS will determine policies related to exchanges' quality initiatives in future rulemaking activity. In the interim, we offer comments and recommendations on quality improvement strategies that center on the implementation of standardized quality metrics related to Qualified Health Plans (QHPs). It will be critical that exchanges think about these quality initiatives from the perspective of *what* information consumers want and need, and *how* they use this information. In other words, we urge that exchanges develop their quality initiatives closely in concert with the development of the web portal and other consumer assistance tools, to ensure that the quality measurement efforts will support and contribute to the use of this information by consumers.

Evidence indicates that consumers make decisions based on information related to choice of provider, data on patients' experiences of care, and outcomes, as they pertain to people with similar health status and conditions as their own. Thus, while we support the use of standard measures of health plan quality – such as the National Committee for Quality Assurance's HEDIS instrument – we also urge that exchanges be required to collect and report on a comprehensive set of consumer-tested measures on outcomes, processes tightly linked to outcomes, patient experience, patient safety and healthcare-acquired conditions; and volume (e.g., number of surgeries performed). The requirements should evolve, and the measure set should grow, as more measures that resonate with those who receive and pay for care become available (e.g., functional status, appropriateness of care, etc.). We also urge the use of measures for which public and private sector purchasers and payers are aligned in data collection and reporting, to further promote this type of alignment across sectors.

These data are not health plan-level, but provider and setting-level, and are critical to helping consumers make informed decisions about which QHP will provide the best quality and value. To facilitate dissemination of this information, states should consider providing links on their web portals to other sources of quality data, such as CMS, the Agency for Healthcare Research and Quality (AHRQ), the Leapfrog Group, the Joint Commission, and others that use nationally recognized measures to assess quality and performance.

Wherever possible, these measures should be reported at the individual-physician level. Physicians may operate as part of a team, but patients and consumers are likely to make health plan choices based on the individual physicians in the QHP's network. Having individual physician-level information "fits" with the way many consumers make health care choices. Similarly, QHPs that include patient-centered medical homes in their network should report on key outcomes – such as care coordination, chronic care clinical improvements, and patient experience – at the medical home level.

In addition to these clinical quality measures, QHPs should be required to report their accreditation status accompanied by easy-to-understand information on what quality measures are required through the accreditation process. More specific comments regarding accreditation requirements and standards are offered later in this document.

The proposed rule notes that exchanges will be responsible for assessing consumers' satisfaction. As noted above, we believe that consumer satisfaction (or "consumer experience" as we prefer to call it) refers to whether or not the exchange performed its operational and administrative roles in a way that made it feasible for consumers to use the exchange as a means of enrolling in the appropriate health coverage. However, in addition to that, we strongly urge that exchanges be required to collect and report data on *patients' experiences of care,* and that patient-reported and patient-generated data measures become a core component of the exchanges quality initiatives. These measures should be implemented across all settings for which measures are available, using tools such as the Consumer Assessment of Healthcare Providers and Services (CAHPS) surveys, which are specified for collecting clinician-level and facility-level data and in the future, data at the patient-centered medical home level. We also suggest consideration of other patient-generated data measures that capture information on patients' perceptions of their care and outcomes. Evidence shows that having actionable data on patients' experiences of care leads to improved health outcomes.[1] Patient-reported and generated data in general are critical for improving overall quality of care, particularly for the highest cost, most complex patients.

Finally, in addition to the use of a nationally standardized minimum set of consumer-tested, core quality measures, exchanges should be empowered to add additional measures based on local, regional, and private sector innovations in quality measurement. One example of a tool for assessing health plan quality that is widely used by private sector purchasers is the eValue8 tool, which provides evidence-based data on health plan quality in critical areas such as consumer engagement, disease management and health promotion, and behavioral health. Recognition of demographic and geographic differences in

[1] M. Meterko, Ph.D., et al., "Mortality Among Patients with Acute Myocardial Infarction: The Influences of Patient-Centered Care and Evidence-Based Medicine," Health Services Research. 2010 Oct;45(5 Pt 1):1188-204.

consumer needs and the nature of local delivery systems, as well as differences in experience with data collection across health plans and states, will strengthen the quality component of the exchanges.

Consumer Assistance Tools and Programs
In all its consumer assistance activities, exchanges should enable consumers to make decisions based on quality and value, particularly in cases where they are faced with numerous Qualified Health Plans that may have different benefits and varying cost levels. Providing quality information, linked to information on estimated costs, is particularly important for consumers with chronic conditions but at the same time combining information on cost with information about quality must be done in a way that is easily understandable to allow for easily-made value-based decisions. The following comments relate to the web portals, the cost calculator, and the Navigator program, but we also want to emphasize the importance of consumers being able to access in-depth, comprehensive assistance in-person and/or by phone.

Web Portals
The web portals offer a significant opportunity for exchanges to provide critical and usable information to consumers that will facilitate better understanding of health care coverage and quality of care. The success of the portals at meeting this opportunity rests upon exchanges requiring QHPs to publicly report the types of quality measures described above. Assuming this foundation is in place, exchanges can subsequently best leverage this opportunity by:

- Providing multiple approaches – and the appropriate decision-support tools – for consumers to navigate through the information according to their learning and usage style.
- Placing information on quality and cost (value) up front and central, and developing tools that are intuitive and intelligent enough to provide alternative layers of decision support to meet the diversity of consumer needs and capabilities.
- Reflecting consumer preferences, and allowing consumers to screen plans by those that have their provider(s) in the QHP's network.
- Establishing display methods to help consumers easily distinguish among various benefit and cost levels, particularly in states where there are many participating QHPs.
- Collaborating with regional public reporting efforts and employer-based efforts, to incorporate their experience and expertise regarding how to best communicate quality and cost to consumers, including assessing what consumers need to know to make the best decisions possible.
- Reporting the availability of QHPs' disease management programs; cost saving opportunities; patient coaching; shared decision-making programs; and prevention and care coordination initiatives, to assist decision-making by those who have multiple chronic conditions.
- Making available composite measures that reflect aspects of enrollee plan experience, such as claim denials, enrollment and disenrollment, complaints, and external appeals outcomes, with the option to drill down for more specific information if interested.
- Allowing consumers to use the web portal to report back on their experiences with the exchange, their health plan, and their provider(s). One of the biggest challenges facing exchanges will be the lack of historical experience for some of the QHPs. Establishing a vehicle for consumer self-reporting is a way to quickly build this type of portfolio.
- Developing innovative strategies for providing quality "proxies" in cases where data metrics are not available. For example, having a "people like me…chose this health plan" tool, which includes information on quality and cost to help guide decision-making.

In developing the content and design of the Web portal, exchanges should assume no audience knowledge of health insurance and low heath literacy levels. Recognizing this is essential in the Exchange's efforts to maximize accessibility and understanding for all users. Toward that end, HHS should require that Exchanges include end-users in the web portal design and testing, to ensure usefulness and navigability to consumers.

Cost Calculator
Given the complexity of determining an individual or family's premium tax credit and cost-sharing reductions, we recommend the federal government provide a consumer-tested, model calculator for use

by state-operated exchanges. Of particular concern is the potential for required repayment of a portion of the advance tax payments if income is higher than expected. We recommend that HHS test model language to inform consumers of this potential liability. The ideal language will inform consumers of the potential, without dampening their willingness to purchase coverage. A standard method of taking less than the full tax credit should also be explored, with the calculator capable of simulating various arrangements. Given this responsibility, as well as the need to provide consumers with usable information on the estimated cost of different QHPs, it is critical that the cost calculator fulfill two roles, and display the following as two distinct functions:

- Help consumers assess their out-of-pocket costs and subsidy amount, given their expected income in the upcoming year, to allow them to avoid a situation in which they would be faced with having to refund a portion of the premium subsidy in the future.

- Provide a "cost at time of care" calculator that provides an estimate of all users' cost-sharing responsibilities, based on the benefit design of each QHP. These cost sharing responsibilities should include annual cost of using care if the consumer's healthcare usage is average, high, or low; annual limit on costs excluding carve-outs, like dental coverage; the baseline deductible, as well as extra deductibles for hospital care, pharmaceuticals (both brand name and generic), and physician visits (primary care and specialty); and other coinsurance and out-of-pocket costs.

This information should be viewable on the same page as summary information on quality and whether the individual's preferred providers participate in a plan's network, preferably in one easy-to-digest page. At the same time, consumers should be able to drill down and access more detailed information on cost, quality, flexibility, and coverage. The Consumers' CHECKBOOK web portal illustrates one model for accomplishing this, and it has been proven through use by those covered under the Federal Employees Health Benefits Program (FEHBP) to provide comprehensive information in a way that can be understood quickly. Simply providing information on deductibles, premiums and cost-sharing, without offering insight into what those costs will mean for the individual and her family when actually using care, will not allow consumers to make the most informed decisions, and could have detrimental effects on their coverage and their care.

Navigator Program Standards

Integral to the sustainability of the exchanges will be consumers' ability to decipher the potentially complex eligibility and enrollment processes. We are very supportive of the Navigator program concept, and have a number of additional suggestions for functions and elements that should be required of Navigator programs to strengthen the program's capacity, allowing it to serve all individuals and small businesses in need of assistance:

- Require that Navigators demonstrate experience with, and linkage to, resources that will enable them to educate consumers about choosing QHPs based on quality and value.
- Conduct detailed analysis of the service area to identify the populations with the highest need for assistance, and avoid awarding Navigator grants to entities that may not be skilled in reaching out to the needs of the community. This analysis should look for geographic concentrations of the target audience as well as other characteristic of the likely eligible population including race/ethnicity, language, age, income, etc. It should also examine the entity's track record of success reaching this or similar populations.
- As noted earlier, require the collection and reporting of quality metrics to that assess Navigator performance and hold the programs accountable both during open enrollment, as well as throughout the year.
- Ensure that at least one of the types of entities serving as Navigators in each exchange be a community or consumer-focused non-profit.
- Institute strong conflict of interest policies. It is critical that Navigators be prohibited from serving as active health insurance agents/brokers in any health insurance market, and that they do not receive compensation from any health insurance issuers, inside or outside the exchange, during their term. Exchanges should monitor referral and enrollment patterns of all Navigators funded entities to ensure that conflicts of interest are not influencing Navigator activity.

Part 155, Subpart H—SHOP

SHOP exchanges have the potential to not only expand coverage options for millions of self-employed and/or employees of small businesses, but to also eliminate the significant burden that too many small employers currently experience due to the enormous amounts of time and resources they find themselves having to devote to determining which plans are most affordable and will provide the best care for them, their families, and their employees. We envision the SHOP exchanges, and the associated assistance tools and Navigators, paving a new pathway for small employers and employees to have greater choice, while at the same time reducing the challenges they face. To accomplish this, we want to see SHOP exchanges provide employees with meaningful and reasonable choices that best fit their health and budget needs. A balance needs to be struck between providing enough choices so as to garner the enrollment numbers necessary to support and sustain the SHOPs, without including what may be viewed as an overwhelming array of choices that could have the adverse effect of making it more difficult for participants to decipher what would be the most appropriate QHP for themselves and their families. Achieving this balance will be critical if SHOPs are to be attractive to small employers and their employees, and remain sustainable beyond 2015, particularly in the relatively volatile and high-transaction small group marketplace.

Functions of a SHOP

For the SHOPs to be successful and sustainable, they must be designed as an easy and attractive tool for small employers to use. Within that context, we strongly urge HHS to require SHOPs to provide cost calculators for both employers and employees, using the same categories described above in the "cost calculator" section. We support the statement in the proposed rule noting that in a merged small group and individual exchange, QHPs for small businesses would still meet the deductible limits that apply uniquely to small group coverage. Finally, as with the metrics suggested above for determining the effectiveness of the individual market exchanges at providing assistance and successfully determining eligibility and tax credit determinations, HHS should establish metrics to assess and hold SHOPs accountable for their functionality in providing small employers with the services they need in order to feasibly utilize the exchange, such as premium aggregation and other administrative simplifications to make participation as easy and attractive as possible.

In regard to how SHOP exchanges set eligibility, enrollment, and application standards, the final rule should:

- Clarify how coordination and information sharing would occur between exchanges if small employers provide coverage through multiple exchanges based on different employee worksites. The rule should also describe how employers can use composite premium rating in situations where workers obtain coverage through multiple exchanges.
- Clearly define the duties of the SHOP to facilitate employee enrollment into QHPs and provide detail on how SHOPs must enforce requirements that QHPs provide notices to employees of their effective coverage dates.
- Require that SHOPs provide: 1) a uniform employee open enrollment period of no less than 30 days. The rule should state that employees must receive advance notice if the QHP in which they are enrolled will no longer be offered through the SHOP for the following plan year; and 2) accessible information about Medicaid, CHIP, and coverage options and information regarding what makes employer-sponsored coverage deemed unaffordable or not comprehensive.

Subpart K—Exchange Functions: Certification of Qualified Health Plan

Certification Standards for QHPs

We urge HHS to establish meaningful criteria and requirements for making Qualified Health Plan determinations. These requirements should include innovative practices regarding payment and benefit design, policies to guard against adverse selection, and network adequacy standards, such as the following:

- Enact a quality improvement strategy that provides incentives for providers to implement patient-centered care initiatives. These should focus on improving health outcomes, preventing

readmissions, improving care coordination, advancing patient safety, reducing medical errors, and reducing disparities in care.

- Use innovative strategies and benefit designs to provide incentives to members that encourage the use of services and programs that improve their health. Health plans should use patient-centered tools designed to discourage the use of expensive services that do not add value, when good alternatives exist. These tools can include shared decision-making materials, as well as strategies such as tiered networks that provide members with incentives to use providers based on their quality and cost ratings.

- Make a commitment to promoting primary and integrated care. Insurers can demonstrate this commitment by paying more for primary care, increasing access to primary care services, and adopting strategies that pave the way for transformation from a fragmented, fee-for-service-based system, to a coordinated, patient-centered, value-based delivery system.

- Demonstrate continuous commitment to promoting efficiencies that will stabilize premium growth rates. Plans competing to enter into and remain in the exchanges must develop tools to avoid using premium increases as a way to make up for inefficient operations.

- Establish policies to avoid adverse selection into and within the exchanges, to ensure both long-term sustainability, and available access to all consumers regardless of perceived risk.

- Be accredited by a nationally-recognized organization. QHP issuers must be recognized by accreditation programs; where appropriate, documentation and measures that are used as part of the accreditation process may be able to satisfy other qualification requirements (e.g. network adequacy, marketing materials, etc.) which would help states leverage scarce resources.

Certification Process for QHPs
We support a requirement that exchanges complete QHP certification processes prior to a QHP being offered in an open enrollment period. We also fully support the requirement that exchanges perform ongoing monitoring of plan compliance with QHP certification requirements, and urge HHS to use the above suggestions to define processes that exchanges must complete in order to comply with this in the final rule.

Accreditation Timeline
HHS should require Exchanges to adopt a one year timeline after certification of a QHP during which a QHP issuer must become accredited if it is not already.

Establishment of Exchange Network Adequacy Standards
It is critical that QHPs have provider networks that can accommodate the needs of the patient population and geographic regions they serve. Networks should be large enough to provide access to treatments and specialists for consumers living with multiple chronic conditions. Large networks are reassuring for consumers who want to have a broad choice of providers. However, to drive consumers to the highest quality care, QHPs with large provider networks should use quality-based metrics to signal which providers are offering the highest quality care, and make this information easily accessible.

Health plans that have smaller networks, but are competitive when it comes to quality and value and can ensure access for all enrollees, should also be eligible to apply for certification as a QHP. While tighter provider networks could signal a health plan's intention to select only the healthiest enrollees, there are plans – such as those built upon a patient-centered medical home framework – that may not have a broad provider network but can still provide the type of coordinated, high quality, high value care that consumers and purchasers seek. Participation by smaller health plans that can demonstrate adequately-sized networks will be critical to reaching consumers in geographic regions where larger plans do not operate. The bar should be set appropriately to ensure that the largest players do not dominate at the expense of innovative, smaller plans.

These recommendations should be incorporated within the context of the NAIC Managed Care Plan Network Adequacy Model Act, which outlines minimum national network adequacy requirements for QHP certification. We also urge that provisions be added requiring QHPs that are health indemnity plans to demonstrate that they have a sufficient choice of providers accepting their health plan to meet the minimum national network adequacy standards. Note that accreditation should never exempt a QHP from filing an access plan as required under the Model Act. We strongly urge the adoption of a requirement that exchanges ensure QHPs provider networks provide sufficient access to care for all enrollees, including those in medically underserved areas, as well as a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost, in the event that no network provider is accessible for that benefit in a timely manner.

We fully support the statement in the proposed rule's preamble encouraging States, Exchanges, and health insurance issuers to consider broadly defining the types of providers that furnish primary care services. Given the millions of Americans who will be entering the health care system, it will be critical that non-physician providers be fully enabled to practice to their level of training. For example, nurse practitioners are entirely capable of providing a wide range of care, working both independently as well as in collaboration with other health care providers; they should be allowed to work to the highest level of their license, and should be reflected in the QHP network. In a similar vein, allowances should be made for providers who may not meet all accreditation requirements but who currently offer the greatest access to care in low-income communities. For example, in our current delivery system, a vast majority of low-income consumers receive care through Federally-Qualified Health Centers (FQHCs); however, FQHC providers do not always have board certification. Providers in other settings may also not be board certified. While the goal is for exchanges to use the highest-quality providers and encourage increased board certification, we believe that there should be other parameters in place to ensure that the providers upon whom low-income consumers rely can demonstrate quality performance. These parameters would keep these providers from being inadvertently shut out of this purchasing model, but still ensure that they meet quality standards parallel to other accredited providers.

Finally, exchanges should be required to collect data on a measure of QHPs' "network adequacy." This measure should be publicly reported to consumers, given the growing trend toward tighter networks, which may have significant effects on consumers' choice and access to care. The measure must be designed in a way that holds QHPs accountable for providing "real time" and accurate information on providers in their networks, which providers are accepting new patients, which provide comparative quality information to the plan or other entities, and which use electronic health records. This information is essential to consumers trying to choose providers.

PART 156: HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

Subpart C—Qualified Health Plan Minimum Certification Standards

Treatment of Direct Primary Care Medical Homes
Exchanges should leverage a range of tools to encourage the integration of recognized PCMHs into QHP networks and not be limited to direct payment arrangements. Toward this end, HHS should require direct primary care medical homes to be officially recognized as a patient-centered medical home by an accrediting organization, such as URAC, NCQA, or the Joint Commission, or under state law, thus ensuring that the direct primary care medical home meets a number of key principles integral to patient- and family-centered care. HHS should elaborate on the requirement that QHPs must coordinate covered services with the direct primary care medical home to address two distinct goals: 1) ensuring that plans offering direct primary care medical homes are covering the full essential health benefit package and that the ten categories of benefits are appropriately balanced; and 2) facilitating care coordination between providers inside and outside of the direct primary care medical home, such as by paying providers specifically for care coordination (including external providers outside the PCMH), and ensuring providers electronically deliver summaries of care for each transition of care and/or referral to another provider.

Accreditation of QHP Issuers

Bodies that are recognized by HHS as QHP accreditors must require plans to report performance on a number of quality and patient experience measures, using tools such as the HEDIS and/or CAHPS surveys. The accreditation process much include public reporting of accreditation and quality reporting results; a review of health plan processes related to marketing practices, appeals processes, utilization management, quality improvement, patient information programs, member privacy, and language access services; and maintain network adequacy standards that are at least equivalent to the NAIC's Managed Care Plan Network Adequacy Model Act.