



September 28, 2011

Donald Berwick, MD, MPH, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building, 200  
Independence Avenue, SW.,  
Washington, DC 20201

RE: Establishment of Exchanges and Qualified Health Plans Proposed Rule (**CMS-9989-P**)

SUBMITTED ELECTRONICALLY

Dear Dr. Berwick:

The National Business Coalition on Health (NBCH) appreciates the opportunity to comment to the Centers for Medicare and Medicaid Services (CMS) on the proposed rule relating to the implementation of the Affordable Insurance Exchanges (“Exchanges”), as mandated by title I of the Patient Protection and Affordable Care Act of 2010 ([Pub. L. 111-148](#)). We are pleased with the guidance provided by the proposed rule for states that elect to establish and operate an Exchange, as well as the proposed requirements that health insurance issuers must meet to participate in an Exchange and offer qualified health plans (QHPs), and the provisions of basic standards that employers must meet to participate in the Small Business Health Options Program (SHOP).

NBCH and our member coalitions are encouraged by the promise and vision of an Exchange program to create an open, transparent, competitive health insurance marketplace where qualified public and private health insurance plans will compete to enroll small businesses and individuals. By organizing populations in the small business and individual markets into a large insurance risk pool, Exchanges seemingly will create the same economies of scale for spreading risk and market leverage enjoyed by large employers and purchasers.

In terms of background, NBCH is comprised of a national network of state and local health coalitions, which represent 7,000 public and private employers, primarily self-insured employers, who voluntarily provide health insurance to 25 million Americans. NBCH and our member employer coalitions have a long history of value-based purchasing of health care and working as an organization, namely through the eValue8 health plan performance evaluation instrument, to encourage member coalitions, employers and providers to collaborate at the local, regional, and national level to improvement in the quality, safety, and efficiency of health care. The cornerstone of our health care policy platform is to ensure our nation has a sustainable, accessible, and affordable high quality health care delivery system.

## **NBCH's Perspective on the Exchange Model:**

NBCH applauds the Administration's recognition of the need to broaden the accessibility and standardization of health care options at the state level. In terms of broad Exchange issues of importance to NBCH and our value-based purchasing priorities, we support the nonprofit status of Exchanges, the nonprofit Consumer Operated and Oriented Plan (CO-OP) Program option in every state Exchange, as well as quality standards and accountability for all plans participating in a state Exchange. However, there also are other major issues being considered at the federal and state level as regulations are being developed and as states are building their Exchange infrastructure. Below we offer our perspective on key issues relating to state health Exchange development, implementation and oversight:

We understand that the primary goal of the Exchanges is to organize and broaden access to health coverage for the millions of Americans who will find affordable coverage because of this program. However, we also believe that the development of Exchanges, both as the federal "fallback or contingency" Exchange and the individual state Exchanges, provide a unique and critical opportunity for addressing the current significant quality and affordability gaps that exist in today's health care delivery system. Thus, the role of the Exchanges can be significantly enhanced if specific efforts related to quality reporting, providing consumers with information on quality and cost of care, and strong consumer and purchaser representation on governance bodies are successfully integrated into the development of both the federal, and state-based, health insurance Exchanges.

We support and welcome the overarching intent and goals of the Exchange program which is to activate consumers to make decisions based on quality and value. Given the existing gap in information in our current health care system, many consumers are not aware of the variations in quality of care and the concept of quality does not automatically link to the challenges and problems consumers face when navigating our fractured health care system. Without more information, many consumers must 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, we understand that Exchanges can play a key role in improving quality across the board. We also hope that states 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. Through Exchanges, states could be able to create a health care environment that supports innovative ideas for improving quality and value, rewarding health plans that encourage higher value care, and providing consumers and employers with information on quality and cost to make informed decisions about their health coverage.

For the future health of our consumers, our care delivery system, and the nation's economy as a whole, Exchanges need to be strong and sustainable over the long-term. To do so, they must be designed to meet the needs of all types of beneficiaries, including individual consumers, small employers, and their employees. For consumers, this includes providing useful information on quality, access, and affordability. For small employers, this means providing a reasonable number of plan and product choices, and offering services such as premium aggregation and other administrative simplifications 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 processes, premium processing, etc., to ease participation by multi-state employers. Exchanges must be able to execute these things without engaging in policies that will result

in adverse selection or putting themselves or other plans at financial risk. NBCH is concerned about the unintentional impact of certain Exchange components (i.e. employee subsidies, low employer penalties, and part-time employee coverage) that could accelerate employer departure, particularly mid-sized employers, from the private health care system. Employers already are contemplating their options within the burgeoning Exchange program about whether to continue to offer increasingly costly health coverage, or pay a relatively small fine, save money, and let employees buy their own subsidized coverage within their state Exchange. The incentive seems clear cut for some types of employers, particularly employers of low wage employees.

To help ensure long-term sustainability of Exchanges, they must support promote and encourage the elements of a “healthy” marketplace, to stimulate appropriate competition among health plans and their providers. These elements include 1) adequate information on both plan and provider performance using evidence-based, standardized quality metrics that support accountability; and 2) transparency of information through public reporting that support consumer choice. Other elements can include using tools that have been proven by the purchaser community to drive improvements in overall value, such as the use of NBCH’s eValue8 to assess health plan performance; engaging in selective contracting based on quality and value; seeking alignment with large employers, Medicare and Medicaid; and when necessary (e.g. when healthy competition is not prevalent in a marketplace); and retaining the authority to negotiate payment rates.

On January 1, 2014, a large new population of individuals will be entering the Exchange system , whether through the private sector Qualified Health Plans (QHPs) or through Medicaid, for the first time, and with that there may be more challenges when it comes to conveying the importance for having and using information on quality and value. We urge Exchanges and QHPs that participate in the Exchanges to demonstrate the ability to provide information and choice tools for new enrollees, many of whom have not had private coverage before and are unfamiliar with the terminology and options regarding health benefits.

The following outlines NBCH’s detailed comments on broad sections of the proposed rule:

- Entities entitled to carry out Exchange functions
- Functions of an Exchange
- Consumer assistance tools and the Navigator program
- SHOP Exchanges
- Requirements for QHPs
- Transparency in QHP coverage

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*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**

With regard to the governance of an Exchange, NBCH strongly urges CMS to require that the majority of voting members of an Exchange governing board be consumer and purchaser representatives. The core role of the Exchanges is to ensure that consumers have access to high quality, affordable health insurance. Having a

majority of consumers and purchasers on the governance board can provide some assurance that insurers, who have an inherent conflict of interest in this setting, do not threaten consumer and employer confidence in the Exchanges. NBCH also believes state Exchanges should be established as an independent, non-profit, organization and not be organized as part of a state agency, where policy development is often controlled by changing political agendas and the health insurance industry being regulated. An independent Exchange should have the advantage of a strong multi-stakeholder governance structure and should include multiple representatives of the employer community as a key customer of the Exchange. It is important for employer representation on Exchange boards regardless of the governance model. An insurer representative would also offer a helpful perspective to the board or advisory board.

NBCH subsequently urges Exchanges to adopt policies requiring a) complete, detailed accounting of transparency regarding potential conflicts of interest; and b) prohibition against voting for those members who do have a conflict of interest. The National Association of Insurance Commissioners (NAIC) has a strong conflict of interest policy that could be a model to follow. We also urge HHS to require that the director or chair of the governing board meet ethical, conflict of interest, and disclosure standards; act in the best interest of consumers; and monitor the composition of a state's governing board and 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, who can advocate on behalf of the needs of employees and small business owners.

- **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**

There are numerous processes and functions related to eligibility, tax credit determination, enrollment, and overall administration of the Exchanges. So NBCH also believes it is essential that the Exchanges' performance should be evaluated and reported as well. Exchanges must be required establish a set of metrics for identifying how well they are performing internally. In particular, they should specifically target the performance of the consumer assistance tools, looking at whether the assistance is being provided in a timely, effective, easy to access manner, and whether it is reaching the right consumers. This could be accomplished via a semi-annual consumer satisfaction survey conducted in multiple settings related to the "doorways" through which consumers may contact the assistance providers. The metrics should also address the accuracy of eligibility and tax credit determinations, any evidence of bias in communications, and the experience of consumers in dealing with the Exchange's appeals process.

The preamble to the proposed rule notes that HHS will determine policies related to Exchanges' internal quality initiatives in future rulemaking activity. In the meantime, Exchanges should be required to collect and report on standard measures of health plan quality to ensure that consumers get useful, comparable, and meaningful information from which to make decisions about their coverage. All product types, including HMOs and PPOs, should be required to report on the same measures in the same way. At a minimum, these measures would include results from the HEDIS and CAHPS surveys, as well as a plan's accreditation status.

As Exchanges evolve, data should be collected and publicly reported on a core set of clinician-specific measures, to relay information on outcomes, process measures that are tightly linked to outcomes, patient experience, and volume (e.g., number of surgeries performed). These measures should be quickly expanded they resonate with those who receive and pay for care become available (e.g., functional status, appropriateness of care, etc.). As Exchanges, and the quality measurement portfolio evolve, comparative information on the quality of care provided by individual physicians, should be provided as well. Physicians may operate as part of a team, but patients and consumers are most likely to make health plan choices based on the physicians in the plan's network. Having individual physician-level information works with the way most consumers make health care choices.

The proposed rule notes that Exchanges will be responsible for assessing consumers' satisfaction. We believe that beyond consumer satisfaction with the Exchange itself, there is a significant need for Exchanges to require plans and providers to set out a glidepath toward collecting patient experience information, particularly at the individual physician level. Evidence shows that having actionable data on patients' experiences of care leads to improved health outcomes. Patient-reported and generated data in general is critical for improving overall quality of care, particularly for the highest cost, most complex patients, as these data provide insight into the level of care coordination unlike most clinical or administrative-data-based measures do. Thus, the concept of Exchanges overseeing "enrollee satisfaction" initiatives must be expanded to include initiatives for collection of patient experience data at the QHP level.

Finally, in addition to the use of a nationally standardized set of core quality measures, Exchanges should look to local innovations in quality measurement and as appropriate, provide information useful to particular populations of consumers. This is a specific function and service that many of NBCH's local business coalitions provide. Recognition of demographic and geographic differences in 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.

- **Required Consumer Assistance Tools and Programs**

In all its consumer assistance activities, Exchanges should enable consumers to make decisions based on quality and value. Combining information on cost with information about quality in a way that is easily understandable will allow consumers to make value-based decisions on their coverage. Providing quality information, linked to information on estimated costs, is particularly important for consumers with chronic conditions. The following comments relate to guidance on public reporting, web portals, the cost calculator, and the Navigator program, but we emphasize as well the importance of being able to access assistance in-person, as well as by phone.

- **Public Reporting by the Exchange**

NBCH believes that each organization administering the Exchange program should commit to full transparency and a robust public reporting strategy. Report cards on comparative plan performance with full pricing and quality based information should be a basic expectation for every Exchange program to promote informed plan choice by individuals and small businesses. Exchanges should also be responsible for producing comparative performance reports for providers in the state, based on aggregating information from all plans participating in the Exchange.

- **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 , and maximizing the opportunity to match these tools (e.g. short-cuts and other techniques to facilitate navigation) with the consumer's learning style.
- Reflecting consumer preferences, and allow consumers to screen plans by those that have their provider(s) in the QHP's network.
- 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.
- Placing information on quality and cost (value) up front and central, and develop tools that are intuitive and intelligent enough to provide alternative layers of decision support to meet the diversity of consumer needs and capabilities. Requiring reporting of information on the availability of disease management programs, cost saving opportunities, patient coaching; shared decision-making programs; and prevention and care coordination initiatives available from QHPS, to assist decision-making by those who have multiple chronic conditions.
- Making available composite measures that reflect aspects of enrollee plan experience, such 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 health 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. NBCH supports 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. NBCH recommends that HHS encourage states to include a separate and distinct component to the Navigator program to include coalitions and affinity groups as distribution partners or networks for information to the Exchange. Compensation for distribution partners should be provided fairly and accordingly as the local or state market dictates.
- 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.
- Implement HHS established quality standards similar to those for evaluating overall Exchange performance to assess Navigator performance and hold the programs accountable both during open enrollment, as well as throughout the year.

### **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. NBCH envisions the SHOP Exchanges Program, and the associated assistance tools and Navigators, to provide small employers greater choice with less barriers and challenges. To accomplish this, however, we strongly suggest that SHOP Exchanges provide meaningful and reasonable choices, without including what may be viewed as an overwhelming array of choices which 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.

## **Functions of a SHOP**

The success and sustainability of the SHOPS hinges on making them an easy and attractive tool for small employers to use. Within that context, NBCH urges 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 suggest that HHS allow SHOPS to present employers with additional choices (outside of the SHOP Exchange) when selecting the menu of plans to offer their employees, provided that HHS requires SHOPS to address the potential for adverse selection (i.e. through very strong marketing standards and other protections to ensure uniformity across plans) and possible age discrimination in premiums charged to older employees. In terms of the merged small group and individual exchange, it makes sense that QHPs for small businesses would still need to 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.

- **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. An important threshold question and operating principle for Exchanges is whether minimum standards for plan participation on the Exchange should be embraced to encourage as many plans as possible to participate or to set plan standards at a higher level which may discourage some plans from participating. Given our experience in the private

sector and the establishment of our own eValue8 tool, NBCH leans in the direction of establishing strong but reasonable participating standards for health plans. The NBCH eValue8 tool represents a ready-made plan performance data collection tool with evidence based metrics, already tested in the private sector, and should be recommended in state planning activities for active use in measuring plan performance.

We recommend that CMS encourage states to be active purchasers of health care. We understand that states need the flexibility to design the model of their health care Exchange that best fits their state market place and the plans that are qualified and available, but it is important for states to support and utilize existing resources that maximize quality, cost containment and transparency. We support any efforts that states make to incorporate value-based purchasing into their Exchange model. The following are other suggested QHP policies to help guard against adverse selection, and improve network adequacy standards:

- 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 long-term sustainability. Plans must provide assurances and demonstrate the presence of policies to eliminate cherry-picking/adverse selection, and ensure that access is available to all consumers regardless of perceived risk.
- Be accredited by a nationally-recognized organization. QHPs 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**

NBCH supports the requirement that Exchanges complete QHP certification prior to the 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. At the same time, 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. 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. While the goal is for Exchanges to use the highest-quality providers and encourage increased board certification, exceptions should be available to ensure that the providers upon whom low-income consumers rely upon are not inadvertently shut out of this purchasing model.

QHP certification should also be an option for health plans that may have smaller networks, but are competitive when it comes to quality and value and can ensure access for all enrollees. 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 standard 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 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 up" to their level of training. For example, nurse practitioners are entirely capable of providing a wide range of care as part of a care team, should be allowed to work to the highest level of their license, and should be reflected in the QHP network.

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**

- **QHP Issuer Participation Standards**

We strongly urge HHS to require QHP issuers to avoid employing benefit designs that have the effect of discouraging enrollment in a particular plan. Value-based benefit design (VBBD) should not be used as a smoke screen for methods of promoting adverse selection. We have a number of suggestions designed to incorporate VBBD in a way that promotes quality, rather than promoting risk-based adverse selection:

QHPs with large provider networks should use quality-based metrics to signal to consumers which providers are offering the highest quality care. While large networks are reassuring for consumers who want to have a broad choice of providers, health plans should use strategies concerned with access, health plans should use strategies , such as quality and cost-based tiering , to signal to consumers which providers are most likely to provide the highest value care.

- **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 **MUST** 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.

Thank you for your consideration of these comments. If you have any questions, please do not hesitate to contact me at [awebber@nbch.org](mailto:awebber@nbch.org), or 202.775.9300, or the leadership of NBCH's Government Affairs Committee, which was instrumental in developing these comments, Caryol Hendricks ([chendricks@ehcark.org](mailto:chendricks@ehcark.org)) of the Employers' Health Coalition in Arkansas, and Elizabeth Mitchell ([emitchell@mehmc.org](mailto:emitchell@mehmc.org)) of the Maine Health Management Coalition.

Sincerely,

A handwritten signature in black ink that reads "Andrew Webber". The signature is written in a cursive, flowing style.

Andrew Webber

President and CEO

## **NBCH Members**

### **Alabama**

ECHO - Employers Coalition for Healthcare Options

### **Arkansas**

Employers' Health Coalition

### **California**

Pacific Business Group on Health

Silicon Valley Employers Forum

### **Colorado**

Colorado Business Group on Health

### **Florida**

Florida Health Care Coalition

### **Georgia**

Savannah Business Group on Health

### **Hawaii**

Hawaii Business Health Council

### **Illinois**

Employers' Coalition On Health

Heartland Healthcare Coalition

Midwest Business Group on Health

Tri-State Health Care Coalition

### **Indiana**

Indiana Employers Quality Health Alliance

Tri-State Business Group on Health

### **Kansas**

Wichita Business Coalition on Health Care

### **Louisiana**

Louisiana Business Group on Health

### **Maine**

Maine Health Management Coalition

### **Maryland**

MidAtlantic Business Group on Health

### **Michigan**

Michigan Purchasers Health Alliance

### **Minnesota**

Buyers Health Care Action Group

Labor/Management Health Care Coalition of the Upper

Midwest

### **Missouri**

Mid-America Coalition on Health Care

St. Louis Area Business Health Coalition

### **Montana**

Montana Association of Health Care Purchasers

### **Nevada**

Health Services Coalition

Nevada Health Care Coalition

### **New Jersey**

New Jersey Health Care Quality Institute

### **New York**

Northeast Business Group on Health

Niagara Health Quality Coalition

### **North Carolina**

Piedmont Health Coalition, Inc.

Western North Carolina Health Coalition

### **Ohio**

Employers Health Purchasing Corporation of Ohio

FrontPath Health Coalition

Health Action Council Ohio

### **Oregon**

Oregon Coalition of Health Care Purchasers

### **Pennsylvania**

Employers Health Coalition of Pennsylvania, Inc.

Lancaster County Business Group on Health

Lehigh Valley Business Coalition on Health Care

Pittsburgh Business Group on Health

### **Rhode Island**

Rhode Island Business Group on Health

### **South Carolina**

South Carolina Business Coalition on Health

### **Tennessee**

Healthcare 21 Business Coalition

Memphis Business Group on Health

### **Texas**

Dallas/Fort Worth Business Group on Health

Texas Business Group on Health

### **Virginia**

Virginia Business Coalition on Health

### **Washington**

Puget Sound Health Alliance

### **Wisconsin**

The Alliance

Business Health Care Group

Fond Du Lac Area Businesses on Health

Greater Milwaukee Business Foundation on Health,  
Inc.

WisconsinRx and National CooperativeRx

### **Wyoming**

Wyoming Business Coalition on Health