



RUPRI Rural Health Panel

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Donald Berwick, MD

Administrator

Centers for Medicare and Medicaid Services

Hubert H. Humphrey Building

200 Independence Avenue, SW, Room 445-G

Washington, DC 20201

By electronic submission at <http://www.regulations.gov>

RE: CMS-9989-P, Proposed Rule: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans

Dear Dr. Berwick:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased to offer comments regarding the Department's Notice of Proposed Rulemaking to implement the new Affordable Insurance Exchanges consistent with Title I of the Affordable Care Act.

The Panel understands that CMS will receive comprehensive comments from a wide variety of sources. Thus we limit our comments to rural-specific issues.

#1 State discretion to allow agents and brokers to enroll individuals and employers in qualified health plans offered through an Exchange and to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through the Exchange.

PROPOSED RULE: Proposed §155.220 essentially tracks the statutory language that provides that states may choose to permit agents and brokers to enroll individuals and employers in QHPs offered through an Exchange and assist individuals in applying for premium tax credits and cost-sharing reductions. It also provides that an Exchange may elect to provide information about brokers and agents on its Web site for the convenience of consumers.

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Providing decision makers with timely, objective, and expert analysis of the implications of policy for rural health

COMMENT: Proposed §155.220 provides standards that apply to agents and brokers who are not acting as Navigators. Navigators are prohibited from receiving any financial compensation from an issuer for helping an individual or small group select a specific QHP while agents or brokers are compensated by issuers. Many potential rural users of Exchanges currently obtain information from local or regional insurance brokers. Bringing brokers into the Exchange functions capitalize on the local knowledge they possess.

However, it is also important that consumers have information about the financial compensation that brokers receive from issuers, including financial incentives to encourage use of one issuer's product over another because of differences in broker fees. It is also important that consumers understand that brokers and agents selling through the Exchange have different financial incentives than do Navigators. Thus, the Panel suggests that the rule require brokers to disclose the fees they receive from issuers and that web-based information on brokers and agents include information about broker and agent fees.

SUGGESTED CHANGES:

(1) Add a new subsection §155.220(a)(3) that reads: "Brokers and agents selling qualified health plans through an Exchange must disclose any fee they receive from an issuer in writing to individuals, employers, or employees whom they assist."

(2) Add a new sentence at the end of §155.220(b) Web site disclosure: "...Such information shall indicate the fees that licensed agents and brokers receive for QHPs sold inside and outside the Exchanges as well as fees for competing non-QHPs sold outside the Exchange."

#2. Navigator standards, use of insurance brokers and agents as navigators, and potential conflicts of interest that arise when persons serving as Navigators also sell insurance products outside the Exchange.

PROPOSED RULE: Proposed §155.210(b)& (c) track ACA's statutory provisions that provide that licensed agents and brokers are eligible to be Navigators, Navigators must "not have a conflict of interest" and Navigators "must not... [r]eceive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP."

COMMENTS: Many potential rural users of the Exchange currently obtain information from local or regional insurance brokers. Bringing brokers into the Exchange functions would capitalize on the local knowledge they possess. The RUPRI Health Panel thus supports ACA's statutory provisions and the proposed regulations which track these provisions allowing brokers and agents to serve as Navigators for the Exchange to allowing them to share their knowledge of the insurance market and insurance products with those who use the Exchange.

However, the Panel wishes to respond to HHS's request for comment on whether Navigators, including insurance brokers and agents serving in that role, should be allowed to receive compensation from health insurance issuers in connection with enrolling individuals, small employers or large employers

in non-QHPs. *See Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866, 41,877 (proposed July 15, 2011) (to be codified 45 CFR 155-56).* Non-QHP products marketed to qualified individuals and small groups will compete with QHPs sold through the Exchanges. There is also the potential for competition between QHPs and non-QHPs in the large group market in those states that opt to open the Exchange to large groups beginning in 2017. Allowing those who serve as Navigators to also be compensated by issuers for selling non-QHPs products that compete with Exchange-offered products is likely to produce at least the appearance of a conflict of interest and possibly a real conflict of interest.

Those who serve as Navigators should be prohibited from receiving compensation from issuers for selling non-QHPs that compete with QHPs. This would not preclude an insurance agent or broker from serving as a Navigator for qualified individuals and employers who are eligible to purchase plans through an Exchange but as a broker or agent for individuals and employers who are not eligible to purchase plans through an Exchange.

Moreover, States have the option to allow insurance brokers and agents to sell QHP plans both inside and outside the Exchange in their role as agents and brokers, rather than Navigators, and continue to be compensated by issuers for all plans sold. *See Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. at 41,877.*

SUGGESTED CHANGE: A new subsection (3) should be added to §155.210(c) providing that a Navigator must not “(3) Receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employee in a non-QHP that competes with QHPs.”

#3 Network Adequacy Standards

PROPOSED RULE: Proposed §155.1050 on Exchange network adequacy standards provides that “An exchange must ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees.”

COMMENTS: HHS requests comments on whether the rule should include additional specific standards which QHP issuers should be required to maintain. Specifically HHS suggests the following: (1) Sufficient numbers and type of providers to assure that services are accessible without unreasonable delay; (2) arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including reasonable proximity and accessibility of providers accepting new patients, (3) an ongoing monitoring process to ensure sufficiency of the network for enrollees; and (4) a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner. *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. at 41,894.*

HHS notes that these standards are based, in part, on the National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act and would create a baseline that each Exchange could interpret and apply in a manner appropriate to local market conditions and

patterns of care. An Exchange would be able to set quantitative requirements where possible to establish clear expectations of access to care.

HHS also seeks comments on whether QHP provider networks should ensure sufficient access to care for *all* (emphasis in original), including those in medically underserved areas. HHS states that such a standard would protect against a network design that does not serve all enrollees' medical needs.

The Rural Health Panel urges HHS to include the four standards listed in their comments to the proposed rule as well as making it clear that the network adequacy standards apply to all enrollees including those in medically underserved areas. While the Panel appreciates that a shortage of providers in rural and other medically underserved areas can make it challenging to create provider networks, the NAIC Model Act provisions contain sufficient flexibility to encourage insurers to serve these communities while protecting consumers from the high out of pocket costs that occur when an insurer sells a product promising in-network coverage when the network is inadequate.

Since PPOs rather than HMOs tend to predominate in rural areas we also encourage HHS to make explicit that these network standards apply to PPOs as well as HMOs.

SUGGESTED CHANGES: Proposed §115.1050 should be supplemented by adding the following italicized language and subsections:

(a) An Exchange must ensure that the provider network of each QHP, including both those that use preferred panels of providers as well as those with closed panels, offers a sufficient choice of providers for all enrollees including those in medically underserved areas, including

(1) Sufficient numbers and type of providers to assure that services are accessible without unreasonable delay;

(2) arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including reasonable proximity and accessibility of providers accepting new patients,

(3) an ongoing monitoring process to ensure sufficiency of the network for enrollees; and

(4) a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner.

#4. Definition of Essential Community Provider for purposes of plan network requirements

PROPOSED RULE: Proposed §156.235 provides that a QHP issuer must include within the provider network of a QHP “a sufficient number of essential community providers, where available, that serve predominantly low-income, medically underserved individuals.”

COMMENTS: HHS solicits comments on what types of providers should be included as essential providers and how to define a sufficient number of essential community providers. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. at 41898-900.

In terms of which providers should be included as essential community providers, the ACA §1311(c)(1)(c) describes essential community providers for network purposes as those “that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4)...and...section 221 of Public Law 111-8” The providers named in the statute are those that are eligible for Section 340B drug discounts such as Community Health Clinics, FQHC Look-alikes, critical access hospitals, rural referral centers, disproportionate share hospitals and others. See U.S. Dep’t of Health & Hum. Servs., Health Resources and Services Administration, *Pharmacy Affairs & 340B Drug Pricing Program*, <http://www.hrsa.gov/opa/introduction.htm> (last visited October 30, 2011).

The Rural Health Panel responds to HHS request for comment on whether the definition of essential community providers “should include other similar types of providers that serve predominately low-income, medically underserved populations and furnish the same services.” The Panel urges HHS to include other such providers. In rural areas a variety of providers provide primary, specialty and hospital services similar to those offered by entities eligible for Section 340B drug discounts. While entities eligible for Section 340B drug discounts play an important role in the nation’s safety net they are not the only providers of care to low income, medically underserved patients, particularly in rural areas. The Panel also notes that the statutory language seems to indicate that while providers who are eligible for Section 340B drug discounts are deemed to be essential community providers that the statute’s use of the term “such as” also indicates a Congressional intent that the implementing regulations recognize other providers as also essential community providers.

The Rural Health Panel suggests that HHS use a functional rather than an organizational test to define other essential community providers for plan networks. The purpose of the essential community provider requirement is to assure that low-income, medically underserved individuals have access to the providers who serve them. A functional test would look to whether the plan network included a sufficient number of providers who actually serve such low income, medically underserved individuals rather than whether the provider has a particular statutory designation.

Since ACA refers to providers who serve “predominately low income, medically underserved” individuals the Panel proposes that any provider for whom at least 51% percent of patients or patient revenue are Medicaid, Medicare and uninsured be classified as an essential community provider. This functional definition of essential community providers would help ensure that those providers who actually serve low income, medically underserved patients are designated as essential community providers. It would also recognize the important role that private physicians and others play in the rural safety net.

PROPOSED CHANGE: An additional subsection (3) should be added to proposed §156.235 which would include within the definition of essential community providers “Providers for whom at least 51% of patients or patient revenue are Medicaid, Medicare and uninsured.”

#5. Role of Exchanges in Oversight of Quality of QHPs

PROPOSED RULE: Proposed §155.200(f) provides that the Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and

rating of health care quality and outcomes, information disclosures, and data reporting as required by various sections of ACA.

COMMENT: HHS has asked for comments on these Exchange functions and indicated that that quality improvement functions will be the subject of future rulemaking. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. at 41,875. The Panel urges HHS to require that Exchanges collect two types of quality measures from their participating health plans:

(1) Measures of quality specific to the health plan (e.g., member satisfaction, member access to provider network that includes their local primary care provider) as an indicator of the quality of service as perceived and experienced by members; and

(2) Aggregated measures of quality about the providers (hospitals, clinics, etc.) with whom the plan contracts (e.g., prevention and screening rates, hospital quality process measures, health outcomes) as an indicator of the nature of health plan contracts with participating providers and where and how the plan is incenting providers toward delivery of high quality care.

Exchanges should be required to publicly report both sets of measures at least annually in a readily accessible and well promoted manner, either directly to the public from the Exchange via an accessible and user-friendly website or via an existing public reporting program website that may exist in the state.

Sincerely,

Sidney D. Watson and on behalf of
The Rural Policy Research Institute Health Panel

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