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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 Pacific Business Group on Health (PBGH) appreciates 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).

PBGH is a coalition of 50 purchasers that seeks to improve the quality and availability of health care while moderating cost. The large purchasers in PBGH represent over 2 million employees, dependents and retirees and $12 billion in annual health care premium expenditures. Our organization was the last administrator of the small business purchasing pool, PacAdvantage, which began as a government program very much like the exchange envisioned in federal healthcare reform.

We support a vision in which exchanges improve the affordability, quality and availability of health care through access to a first-class, consumer-oriented health insurance marketplace and high-value delivery system. In the current environment, coverage is becoming increasingly expensive with more restricted benefits and practices that often do not achieve standards of high quality health care. The exchanges present an opportunity to transform the marketplace – enabling consumers and purchasers to select coverage that is affordable and of high value.

To accomplish market transformation, exchanges should be strong purchasers acting on behalf 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 *affordable* 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 proposed rules make headway towards the kind of standardization that will allow more robust employer participation in the exchanges, such as establishing standard forms and uniform processes for eligibility and enrollment. Without this kind of standardization, multi-state employers will need

to expend significant resources monitoring and helping their employees navigate the complex rules and processes of a number of states along with the Federal model. A consumer-oriented marketplace would be one in which employees and retirees can move across state lines and smoothly transition their health coverage without the burden and cost of learning a new set of rules and processes. Therefore, PBGH supports HHS codifying requirements that state exchanges use nationally standardized forms, definitions and administrative processes where possible and appropriate.

The following are key strategies the exchanges should adopt to foster a "healthy" marketplace, characterized by competition among health plans and their affiliated providers on quality and affordability.

(1) Provide adequate information on health plan and provider performance using evidence-based, standardized quality metrics that support accountability
(2) Promote transparency of quality and cost information at the health plan and provider levels through public reporting that supports consumer and employer choice
(3) Use surveys like eValue8 to assess health plan performance and make performance information transparent to consumers and purchasers
(4) Engage in selective contracting with health plans as needed by setting high standards for quality and value
(5) Standardize cost-sharing arrangements within Qualified Health Plans offered in each "metal tier" to the extent needed to avoid consumer confusion and prevent adverse selection
(6) Seek alignment with the purchasing strategies of large employers, Medicare and Medicaid, and Accountable Care Organizations;
(7) 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 or exacerbate costs in other portions of the market
(8) Monitor, address and mitigate the effects of adverse selection if it occurs

We urge exchanges and Qualified Health Plan issuers that participate in the exchanges to provide information and choice tools for new enrollees, many of whom have not previously had private coverage and are unfamiliar with the terminology and options regarding health benefits. PBGH supports HHS' emphasis on providing meaningful access to individuals with limited English proficiency. We also encourage production of materials in languages that reflect the consumer demographics of each state, to improve access to coverage among non-English speaking populations.

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

On behalf of the millions of Americans represented by PBGH members, we appreciate the opportunity to provide comments on the proposed Health Insurance Exchange regulations. If you have any questions, please contact Bill Kramer, Executive Director for National Health Policy at the Pacific Business Group on Health (bkramer@pbgh.org).

Sincerely,

Bill Kramer
Executive Director for National Health Policy
Pacific Business Group on Health

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

We support the models for Federal partnership proposed by HHS on September 19th and would strongly encourage states to take advantage of Federal assistance to gain efficiencies. We encourage robust stakeholder engagement to ensure that the models do not produce unintended consequences that harm consumers.

155.110: Entities Eligible to Carry Out Exchange Functions

PBGH supports the comments submitted by the Consumer-Purchaser Disclosure Project, that the exchange governance board should be made up of consumer and purchaser representatives who demonstrate no conflicts of interest related to the business of the exchange. States should take advantage of the expertise of insurers, brokers, and others through a technical advisory committee. In states that elect to allow other types of stakeholders on the governance board, the majority of the board should remain comprised of consumers and purchasers to protect against erosion of consumer and employer confidence in the exchanges.

"Consumer" representatives should be individuals who have significant personal experience interacting with commercial health insurance and/or public programs, either as patients, family caregivers, or both. Similarly, we define a "purchaser" 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.

Subpart C: General Functions of an Exchange

155.200: 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 Reporting as a Function of the Exchange

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. 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.

Exchanges should be required to collect and report on the small number of standard measures that help consumers assess the quality of the health plan's core functions – customer service, claims handling, information services, access to care. All product types, including HMOs and PPOs, should be required to report on the same measures in the same way. HHS should focus on putting measurement systems in place that help consumers choose based on what is important to them and their health -- doctors and care systems (e.g., Accountable Care Organizations, Patient-Centered Medical Homes, and Ambulatory Intensive Care Units), experience of care, and outcomes as they pertain to people with similar health status and conditions as their own. Exchanges should collect and publicly report data on a core set of clinician-specific measures, to relay information on outcomes, process measures (only where outcomes data is unavailable), patient experience, and volume (e.g., number of surgeries performed). This measure set should quickly expand as more measures that resonate with those who receive and pay for care become available (e.g., functional status, appropriateness of care, etc.).

Wherever possible, these measures should be reported at the individual-physician level. Physicians may operate as part of a team, but many patients and consumers are likely to make health plan choices based on the physicians in the plan'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 and employer satisfaction (or "experience") refers to whether or not the exchange performed its operational roles in a way that made it feasible for consumers and employers 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 set of core quality measures, exchanges should incorporate local innovations in quality measurement. 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.

155.205 Required 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.

The performance of Exchanges in providing appropriate consumer assistance through multiple communication channels must be measured and publicly reported annually to gauge successful compliance with the requirements of this section. These measures must be auditable standards that ensure that the consumer assistance is timely, effective, easy to access, and reaches the right consumers. These measures should include, but are not limited to:

- Regular customer satisfaction surveys to measure overall Exchange performance with respect to consumer assistance functions, including detail by activity and doorway. Using open ended questions, surveys or focus groups must assess which consumer needs are not being met, if any.

[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.

- Tracking accuracy of eligibility determinations made by the exchange, and using this evidence to correct related procedures that might fall into the consumer assistance function, as well as the eligibility determination function.
- Usage reports showing which activities are being accomplished using which doorways
- Measures to gauge performance of the call center, web portal, and navigator/outreach program

States and/or HHS should publish public, annual performance reports that include a description of the methodology used to assess performance in this area, and those reports should be used to ensure that efforts to identify and reduce unnecessary duplication do not compromise access to consumer assistance. Exchange planners should anticipate that some duplication will be needed to ensure ready access to timely, accurate, and responsive consumer assistance.

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.

As CMS is aware, PBGH is currently carrying out research to assist consumers in choosing a qualified health plan in the Exchanges that meets their needs. There is high likelihood that many consumers could make the "wrong" plan choice in selecting a health plan on a Health Exchange. Insurance product complexities, four levels of benefit designs, potentially large numbers of product offerings, subsidy calculations, and eligibility status that can vary within a family are among the many daunting aspects of Exchange plan choice. This research will produce IT business requirements for plan choice software and data elements needed from issuers for plan choice. We strongly encourage states and CMS to take advantage of these tools to promote successful consumer decision-making.

Cost Calculators

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.

155.240 Payment of Premiums

We strongly support the requirement that exchanges accept an aggregated premium paid by a qualified employer for coverage through the SHOP. Collecting and aggregating premium payments is one of the most useful customer service function a SHOP can offer qualified employers, and is a critical component of any model in which employees are provided choice among multiple plans. Premium payment processes should be standardized across states to make it easier for consumers and employers to navigate the market.

Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

155.405: Single Streamlined Application

PBGH strongly supports the use of a uniform enrollment form across states and suggests that HHS should resist approval of alternative applications. Requiring this type of uniformity contributes to a consumer-oriented marketplace.

Subpart H— Exchange Functions: Small Business Health Options Program (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 employers currently experience due to the enormous amounts of time and resources they 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, to pave a new pathway for employers to have greater choice, while at the same time reducing the challenges they face. 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.

155.705: Functions of a SHOP

The success and sustainability of the SHOPs hinges on making them an easy and attractive tool for small employers, and eventually large 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.

While adequate choice of plans is an important principle, we believe that choice should be meaningful, reasonable, and not excessive. It has been shown that an excessive number of product options can be overwhelming to consumers and employers, who ideally want several high quality options that offer good value from which to choose. Additionally, greater choice for each small business employee presents the possibility of adverse selection, where older or sicker employees may gravitate to higher cost plans while younger or healthier individuals may concentrate in cheaper plans. As such, we believe that while employers should not be allowed to limit employees to one insurance carrier, they should be allowed to limit their employees to two or more carriers. They should also be allowed to limit their employees to a specific "metal tier" benefit level. The final rule should also grant states the latitude to structure employee coverage choices in the SHOP to prevent adverse selection.

Additionally, the preamble to section (b)(4) states that HHS anticipates that, "most SHOPs will also include the employer and employee contribution for the QHP selected by each employee as a service to employers." We recommend that this function be formally required of SHOPs, as it will increase the usefulness of a monthly aggregated bill to employers, who will more easily then be able to collect premium shares from workers and understand their business costs for providing worker coverage.

We strongly support the requirement that plans may not vary rates for a qualified employer during its plan year. We agree with the statement in the preamble that, "if an employee is hired during the plan year or changes coverage during the plan year during a special enrollment period, the rates set at the beginning of the plan year must be the rates quoted to the employee." Additionally, we support the requirement that SHOPs must set a uniform policy for the frequency with which QHP rates may be changed for newly sold coverage. A national standard for enrollment duration and timeline would significantly ease multi-state employer participation in the future.

The preamble to section 155.705(b)(3) solicits comments on whether minimum participation rate requirements should be applied in SHOPs, and if so, how the rates should be calculated and what that rates should be. As the preamble recognizes, minimum participation rules serve to mitigate the risk of adverse selection in group plans by requiring a larger, diverse segment of a group to enroll in coverage. The need for such a requirement will lessen due to various ACA provisions, including the individual responsibility requirements, potentially warranting a waiver of these requirements in the SHOP Exchange. However, if minimum participation rules are applied to the SHOP, we recommend that any participation rate calculation excludes from the count of eligible employees those who already have creditable coverage, such as through a spouse's health plan, Medicare, or Medicaid. For example, if a minimum participation rate is established, the requirement should be considered to be met by the participation the required percentage, whatever it is, of workers without other sources of creditable coverage in a group. Such a method of calculating employee participation would ensure that employers are not restricted from offering coverage to workers through the SHOP, helping to meet the goal of maximizing SHOP participation among small employers.

Given our experience with PacAdvantage, we recommend that overall participation rules for small employers in the exchange should be the same as those used in the small group market outside the exchange. SHOPs should also make certain to count eligible employees the same as the outside market.

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 a 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.

155.710 Eligibility standards for SHOP

We support the requirement that SHOPs must offer employers with multiple worksites the opportunity to provide coverage for employees via the SHOP in which the employee's worksite is located. Employers with multiple worksites either within a state or across two or more states may have employees whose service areas may be vastly different. This provision prevents employees not located at the primary work site from being limited to coverage options that may not serve the appropriate service delivery area. In instances when an employer may participate in more than one SHOP to provide coverage to multiple work sites, the affected two or more SHOPs should be required to ensure coordination and information sharing necessary to ensure that all required functions are provided to the employer and each employee. The rule should also describe how employers can use composite premium rating in situations where workers obtain coverage through multiple exchanges

155.715 Eligibility Determination Process for SHOP

We support the requirement that SHOPs use only two application forms: one for employers and one for employees. This will ease the administrative burdens placed on employers and employees seeking SHOP coverage.

155.720 Enrollment of employees into QHPs under SHOP.

The final rule should 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.

We also support the requirements of section 155.720(b) that SHOPs establish uniform enrollment timelines and processes for enrollment. It is critical that these timelines be standardized so that, as described in the preamble, they do not differ by issuer and cause employers confusion and restricted choice due to varying enrollment deadlines

155.725 Enrollment periods under SHOP.
SHOPs must provide 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. We also strongly support the requirement that SHOPs have a standardized annual open enrollment period for qualified employees prior to the completion of the employer's plan year. We recommend that section 155.725(e) be modified to read that the "SHOP must establish *a standardized* annual open enrollment period…" to clarify that this period must be uniform for all carriers

155.730 Application standards for SHOP.
SHOPs must be required to provide accessible information about Medicaid, CHIP, and coverage options and information regarding what makes employer-sponsored coverage deemed unaffordable or not comprehensive.

We support the requirement that the SHOP must use a single application for eligibility determination, QHP selection, and enrollment for qualified employees across states. This requirement will make the application process simple for employees, who will become familiar with the application over time. We recommend that the SHOP application be as similar as possible to the individual market application (although the amount and type of information requested on the SHOP application may be different) so that information sharing across Exchanges is easy when people transition between group and individual coverage (and vice versa) and so that individuals become familiar and comfortable with all Exchange (SHOP and individual) applications.

Subpart K—Exchange Functions: Certification of Qualified Health Plan

155.1000 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.

- Conform to 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.

155.1010: 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.

155.1045 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.

155.1050 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 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.

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. 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, we believe that in this case 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

Subpart C—Qualified Health Plan Minimum Certification Standards

156.245 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.

156.275 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.