Health Insurance Exchanges Final Rule

HHS released the final rule on the health insurance Exchanges established in the ACA. This side-by-side compares ACP's public comment recommendations with the language from the final rule. Some of the elements of the Exchange are in interim final rule status, and are open for further comments. However, they are not related to ACP's recommendations. Since the States will have significant flexibility in establishing Exchange rules, ACP Chapters may have ample opportunity to advocate for effective Exchanges. Staff has noted potential action items for Chapters.

HealthCare.gov Press Release on Rule

Final Rule

ACP Public Comment letter

155.420: Special enrollment periods: Proposed rule established special enrollment periods permitted for certain life events (based on HIPAA) e.g. loss of job, divorce, loss of minimum essential coverage, etc. (pg. 306, Final Rule) Several commenters, namely health insurance issuers, asked HHS not to add any additional special enrollment periods to those listed in proposed §155.420(d). Several other commenters recommended additions to the rule, **including special enrollment periods for certain changes in plan provider networks**, exhaustion of the COBRA disability extension, denial of services due to a provider's moral or religious opposition, and pregnancy. Response: The Affordable Care Act establishes that Exchange special enrollment periods follow those specified in section 9801 of the Code and part D of title XVIII of the Act. The additional special enrollment periods suggested by commenters are not specified in the Code, nor are they similar enough to those available under the Act for HHS to include them in the final rule. Therefore the final rule implements the statute without additions. We note, however, that the special enrollment period for exceptional circumstances in §155.420(d)(9) of this final rule provides an additional opportunity for enrollment when unforeseen circumstances arise.	ACP believes that those enrolled in Exchanges should have access to an adequate number of physicians who specialize in primary care as well as other specialists. In the event that this fails to be the case, individuals and small businesses should be permitted to enroll in a QHP during a special enrollment period if their physician (e.g. primary care physician) is no longer a part of the health plan network and/or it is determined that the QHP in which the individual is enrolled is unable to meet network adequacy standards. HHS should establish minimum standards for special enrollment periods that are the result of significant changes in provider network adequacy. Such a policy will provide an important safeguard that ensures continuity of care in the event that a physician is no longer a part of a QHP plan network. Staff comment: While the rule acknowledges commenters suggestion that special enrollment periods be provided if provider networks become inadequate, the suggestion does not reflect the direction of the statute. The rule discusses the potential for special enrollment due to "exceptional circumstances" but according to the proposed rule, this would include natural disasters or other events that would prevent an individual from enrolling on a timely basis. Individuals would have to demonstrate to the Exchange that they meet definition of exceptional circumstances.
155.1050/156.230 – Network adequacy standards.	While College policy does not suggest a specific model for network adequacy standards, ACP urges

Comment: Many commenters offered feedback on the network adequacy standard, initially included in proposed §155.1050. Some commenters supported the flexibility provided to States in the proposed rule, noting that such flexibility could facilitate the alignment of markets inside and outside of the Exchange. Conversely, many commenters recommended that HHS establish a national, uniform standard for network adequacy. These commenters offered numerous standards HHS could adopt, including the NAIC Managed Care plan Network Adequacy Model Act, or the current standards for Medicare Advantage plans, Medicaid managed care plans, or TRICARE plans. Finally, a few commenters generally requested that HHS clarify the meaning of "sufficient number" of providers. Response: A number of competing policy goals and considerations come into play with examinations of network adequacy: that QHPs must provide sufficient access to providers; that Exchanges should have discretion in how to ensure sufficient access; that a minimum standard in this regulation would provide consistent consumer protections nationwide; that network adequacy standards should reflect local geography, demographics, patterns of care, and market conditions; and that a standard in regulation could misalign standards inside and outside of the Exchange. In balancing these considerations, **we have modified §156.230(a)(2) in this final rule to better align with the language used in the NAIC Model Act.** Specifically, the final rule establishes a minimum standard that a QHP's provider network must maintain a network of a sufficient number and type of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be available without unreasonable delay. We believe this modification provides additional protection for consumers by communicating our expectations with respect to the number and variety of providers that should be present in a QHP's provider network. Further, the modified standard establishes a baseline ("all services…without unreasonable delay") against which network adequacy can be measured. We note that nothing in the final rule limits an Exchange's ability to establish more rigorous standards for network adequacy. We also	HHS to clarify the definition of "sufficient choice of providers" to ensure that patients will have timely access to needed primary and specialty care physicians that fulfill the geographic, cultural and linguistic, and financial needs of the local market. QHPs must also be required to develop networks that meet the needs of underserved and complex-need populations, including patients with multiple chronic illnesses who may receive care from a variety of primary and specialty care physicians. Physicians should have the right to apply to any health care plan or network in which they desire to participate and to have the application judged on the basis of objective criteria that are available to both applicants and enrollees. At a minimum, QHPs should be required to meet the standards outlined in the proposed rule based on the NAIC Managed Care Plan Network Adequacy Model Act, specifically, QHP's must maintain "sufficient numbers and types of providers to assure that services are accessible without reasonable delay; arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients; an ongoing monitoring process to ensure sufficiency of the network for enrollees; and 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." Staff comment: The rule reflects ACP's request that network adequacy standards align with the NAIC Model Act. However it is imperative that States adopt stringent rules and conduct strong oversight of health plan networks to ensure patients have access to physicians and other health care professionals.

believe that this minimum standard allows sufficient discretion to Exchanges to structure network adequacy standards that are consistent with standards applied to plans outside the Exchange and are relevant to local conditions. Finally, placing the responsibility for compliance on QHP issuers, rather than directing the Exchange to develop standards, is more consistent with current State practice.	
Network adequacy standards (cont'd) Comment: Several commenters urged HHS to codify the potential additional standards listed in the preamble to the proposed rule (access without unreasonable delay, reasonable proximity or providers to enrollees' homes or workplaces, ongoing monitoring process, and out-of-network care at no additional cost when in-network care is unavailable), **with the largest number of commenters expressing support for the provision of out-of-network care at no additional cost when in-network care is unavailable.** Other commenters recommended specific alternatives to these elements, such as a "60 minutes or 60 miles" or "15-20 minutes" standard. Response: Based on comments, we have modified §156.230(a)(2) in this final rule to codify the standard that services must be available without unreasonable delay. With respect to the other specific suggestions offered by commenters, we are concerned that the proposed standards may not be compatible with existing State regulation and oversight in this area. We believe that the modification to final §156.230(a)(2) strikes the appropriate balance between assuring access for consumers and recognizing the historical flexibility and responsibility given to States in this area.	At a minimum, QHPs should be required to meet the standards outlined in the proposed rule based on the NAIC Managed Care Plan Network Adequacy Model Act, specifically, QHP's must maintain "sufficient numbers and types of providers to assure that services are accessible without reasonable delay; arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients; an ongoing monitoring process to ensure sufficiency of the network for enrollees; and **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**." Staff comment: The reg seems to yield to the States that patients should be able to access out-of-network providers at no additional costs if in-network providers are not readily available. This may be an opportunity for Chapters to advocate for State regulators to adhere to the NAIC Model, which established the out-of-network provider access language.
Network Adequacy cont'd Comment: A few commenters supported the language in the preamble to the proposed rule encouraging Exchanges and QHP issuers to consider broadly defining the providers that can furnish primary care services. However, other commenters raised concerns about this broader definition and noted that other programs, such as Medicare and Medicaid, identify a limited set of providers who may be considered primary care providers.	The College appreciates recognition of the primary care shortage experienced by communities across the nation. ACP is deeply concerned about the future of primary care medicine and has offered a framework to reinvigorate the profession to ensure that future patients have access to quality care provided by primary care physicians….. However, the College is concerned that the proposed rule encourages States, Exchanges, and health insurance issuers to define the types of providers that furnish primary care services in a

Response: We continue to encourage Exchanges to consider a broader definition of the types of providers who may furnish primary care services, because this should improve access to such services for consumers, particularly those in medically underserved or rural areas. We also recognize that the definition of a "primary care provider" should be consistent across health insurance programs to the extent possible, and we encourage Exchanges to be mindful of existing definitions and approaches in other health insurance programs when outlining corresponding standards for QHP issuers participating in the Exchange. All provider contracts executed by QHP issuers participating in the Exchange must be fully compliant with State scope of practice laws.	way that may blur distinctions in the training and skills of physicians who specialize in primary care with those of other health care professionals with more limited training. Physicians and non-physician health care professionals complete training with different levels of knowledge, skills, and abilities that while not equivalent, are complementary. For example, internal medicine specialists, extensively trained in the delivery of primary and comprehensive care, receive 4 years of premedical college education, 4 years of medical school that includes 2 years of clinical rotations, 3 years or more of clinical residency training with up to 80-hour workweeks, and continued medical education. In contrast, a nurse practitioner must be certified as a registered nurse and have completed a graduate-level degree. As trained health care professionals, physicians and non-physician health care professionals share a commitment to providing high-quality care. However, physicians are often the most appropriate health care professional for many patients. ACP believes that physicians and non-physician health care professionals working together in a team-oriented practice, such as the physician-led patient-centered medical home, is a proven model for delivering high-quality, cost-effective patient care. The College recognizes the scope of practice of licensed health professionals is governed by State law. However, State legislatures should make such decisions based on scientific evidence that they have the requisite skills and training to provide the desired scope of services. Further, patients have the right to be informed of the credentials of the person providing their care to allow them to understand the background, orientation, and qualifications of the health care professionals providing their care and to better enable them to distinguish among different health care professionals. HHS should clarify that in developing a definition of primary care provider, States, Exchanges, and health insurance issuers adhere to this standard. Staff comment: While the reg does not establish a primary care provider definition, it does say that Exchanges must accept State scope of practice laws. Chapters may work with States to define and enforce scope of practice statutes that reflect ACP policy.

Many commenters offered feedback on whether the final rule should include a broad prohibition against deceptive marketing practices. A number of commenters supported such a prohibition and suggested specific Federal standards that HHS could adopt, such as Medicare Advantage, Medicare Prescription Drug Program, or Medicaid standards. Conversely, many commenters supported State flexibility with respect to marketing rules and oversight. A few commenters expressed concern that a Federal standard could be overly restrictive. Response: States have significant experience with, and existing infrastructure to support, monitoring and oversight of health plan marketing activities. The National Association of Insurance Commissioners (NAIC) has provided guidance to the States in the form of the Model Unfair Trade Practices Act. The Model Act has been adopted by 45 States and the District of Columbia. The NAIC has also issued an Advertisements of Accident and Sickness Insurance Model Regulation, which has been adopted by 42 States. Both the Model Act and Model Regulation are extensive and position States to address misleading or deceptive practices. As a result, we are finalizing the marketing standards with the flexibility afforded in the proposed rule.	The College advocates for robust oversight of QHP marketing activity to ensure that patients aren't provided false or misleading information on benefits, terms, conditions, cost-sharing requirements, provider networks, and other crucial information that would hinder their access to appropriate quality care. ACP supports efforts to prevent the use of fraudulent, deceptive and high-pressure sales tactics to enroll patients in health insurance plans, and to penalize those individuals and organizations that engage in such activities. Standards for marketing QHP health benefits plans must ensure that marketing materials must not include false or materially misleading information; and sales agents do not partake in abusive enrollment procedures such as not showing potential beneficiaries the listing of covered insurance benefits. Staff comment: Chapters may have an opportunity to work with state consumer advocates to push for adoption of the NAIC marketing rules. Eliminating aggressive/deceptive marketing is an important goal in preventing risk selection.
General standards for Exchange notices (§155.230) Comment: Many commenters recommended that we provide specific standards and thresholds for translation of written information, and be understandable to limited English proficient populations. One common suggested threshold was to provide written translations where 5 percent or 500 limited English proficient individuals reside in the State or Exchange service area, whichever is less. Many commenters also recommended we add specific standards with respect to oral interpretation, including at no cost to the individual, and informing individuals how to access these services through use of "taglines" in at least 15 languages. A few commenters asked for flexibility for States in developing language services standards as States' populations and needs differ, and one commenter expressed concern that a specific, uniform standard could pose an unreasonable burden.	The College is pleased that the proposed rule would require Exchanges to provide access to information for people with limited English proficiency as well as patients with disabilities. To ensure that patients with limited English proficiency can find a health plan that meets their cultural and linguistic needs, Exchanges should also disclose whether qualified health plans provide reimbursement to physicians and other health care professionals that reflect the cost of language services and additional time involved in providing clinical care for limited English proficiency patients. ACP policy recommends that a national clearinghouse be established to provide translated documents and patient education materials; the health insurance Exchange may fulfill this role. Staff comment: Staff will review guidance on this issue when it is released.

Response: In response to these comments, we have modified our proposed regulation at §155.230(b) to cross-reference the accessibility, readability, and translation and oral interpretation standards outlined in §155.205(c). We plan to put forth guidelines relating to these standards in upcoming guidance.	
155.205 – Required consumer assistance tools and programs of an Exchange. We are finalizing the provisions proposed in §155.205 of the proposed rule, with the following modifications: we renumbered proposed paragraphs (b)(3) through (b)(6) as (b)(2) to (b)(5) in the final rule. We clarified in paragraph (b)(5) of this final rule that a qualified individual may select a QHP on the Exchange Web site to initiate the enrollment process, rather than completing the entirety of the enrollment process on the Web site. We moved the standard regarding the calculator to paragraph (b)(6) of this final rule. We redesignated paragraph (c)(1) and clarified standards for persons with disabilities, including the provision of auxiliary aids and services at no cost to the individual and that Exchange Web sites must be accessible. We added paragraph (c)(2) to outline standards for limited English proficient persons, including that oral translation be available, written translation be available, and that the availability of language services be displayed with taglines written in each respective language, and in paragraph (c)(3) that individuals must be made aware of the availability of these services. Finally, we made several minor technical and non-substantive changes.	ACP requests that in addition to the required information listed, the final rule clarify that State Exchanges make available the qualified health plan's coverage rules (including amount, duration, and scope limits) as well as out-of-pocket cost-sharing (both inside and outside plan networks, including estimates of balance billing liabilities for out-of-network care) for all essential services included in the benefits package. Staff comment: Most of the information will be provided, but it is unclear if balance billing estimates will be required.
155.200 Functions of an Exchange Comment: Several commenters submitted comments in response to our proposals in §155.200(f) supporting the use of national quality standards, State flexibility in implementation, reporting quality information to consumers and the evaluation of Exchanges as well as QHPs. Response: As noted in the preamble to the proposed rule, we intend to address the content and	155.200 – Functions of an Exchange. Exchanges will have a role in evaluating the implementation, oversight, and improvement of the quality and enrollee satisfaction initiatives established in the ACA, among others. The proposed rule encourages States to consider additional functions of the Exchange. The College believes that Exchanges should evaluate and disclose to consumers the extent to which qualified health plans (QHP) have redesigned their health care financing, payment, and delivery systems to emphasize prevention, care

manner of quality reporting under this section in future rulemaking. In addition, the State Exchange Implementation Question and Answers published by HHS on November 29, 2011 discusses the implementation of the quality rating system for QHPs at question 11.	coordination, quality, and use of health information technology through the Patient-Centered Medical Home. The College looks forward to reviewing future rules on the matter of quality improvement functions performed by the Exchange. Staff comment: No mention of ACP's suggestion that Exchanges report their efforts to encourage delivery system reforms. This may be detailed in future rulemaking.
155.110 - Exchange governing boards Comment: Commenters suggested broadening the list of groups identified as having a conflict of interest in proposed §155.110(c)(3)(ii) to include: health care providers; anyone with a financial interest; anyone with a spouse or immediate family with a conflict of interest; major vendors, subcontractors, or other financial partners of conflicted parties; members of health trade associations and providers; and, health information technology companies. Commenters recommended that such groups be limited or prohibited from participation in an Exchange. Other commenters recommended that individuals with ties to the insurance industry participate through technical panel or advisory group instead of through board membership. Response: As proposed, §155.110(c)(3)(ii) ensures as a minimum standard that the groups with the most direct conflict of interest cannot form a majority of voting members on a governing board. We believe that further definition of conflict of interest may create inconsistencies with State law and other existing State standards, but note that Exchanges may expand the list or further define conflict of interest. For example, a State may elect to prohibit any conflicted members from serving on the board.	The College strongly believes that State Exchange governing boards must include a practicing physician – preferably an internal medicine specialist –among the membership. Physicians will be intimately involved in the implementation of the ACA and will provide leadership in the development and operation of new health care payment and delivery models designed to promote evidence-based, coordinated, high quality care. Further, many internists are also small business people, as most have solo or small group practices. ACP supports efforts to balance the governance board in favor of consumers and small businesses and cautions Exchange governing boards from permitting too many insurance industry representatives among the membership. Failing to mitigate this conflict of interest may undermine the Exchange's ability to encourage access to affordable health insurance plans, require insurers to negotiate bids and terms with physicians and other health providers, and limit nefarious marketing practices that may lead to risk selection that excludes sick individuals. Some States have already appointed a disproportionate number of insurance industry-aligned representatives to their governing boards. ACP requests that the final rule clarify that physicians and other health care providers are not defined as having a conflict of interest unless they are engaged in the business of selling health insurance. Staff Comment: The final rule says that, among other things, "representatives of health insurance issuers, agents, brokers, or other individuals licensed to sell health insurance may not constitute a majority of the governing board." So, a contracted entity charged with conducting exchange functions cannot be an insurer. Presumably, State Medicaid or State department of insurance would be the likely contracted entities.

	The final rule also requires that an Exchange governing board have a consumer among the membership. Although governance boards would be required to include a consumer rep, insurers and brokers - even if they're in the minority - may still have disproportionate influence. ACP recommended that a physician be amongst the board membership and not be included in the categories of individuals with a conflict of interest. According to the final rule, some commenters requested that health care providers be identified as having a conflict of interest, but the final rule only says that "(the proposed rule) ensures as a minimum standard that the groups with the most direct conflict of interest (NOTE: i.e. insurers and brokers) cannot form a majority of voting members on a governing board. We believe that further definition of conflict of interest may create inconsistencies with State law and other existing State standards, but note that Exchanges may expand the list or further define conflict of interest. For example, a State may elect to prohibit any conflicted members from serving on the board." Since health care providers are not specifically excluded from those with a conflict of interest, Chapters might work on ensuring physicians are on the board.
155.130 – Stakeholder Consultation Comment: Many commenters recommended that HHS add additional categories of stakeholder groups to proposed §155.130, including: a nonprofit community organization; unions; representatives of individuals with disabilities; minorities; advocates for individuals with limited English proficiency; essential community providers; employees of small businesses; stand-alone dental plans; health care consumer advocates; experts in low income tax policy; experts in privacy policy; and professional organizations representing specific health care providers. Several commenters requested clarification on what types of health insurance issuers and providers fall under the categories for consultation. A few commenters suggested that we narrow the list of stakeholders. Response: We recognize that Exchange consultation with the above groups would help	155.130 – Stakeholder Consultation. The proposed rule mandates that a diverse array of stakeholder groups be consulted periodically during establishment and operation of Exchanges. A number of these groups were listed in the ACA, including educated health consumers and representatives of small businesses and self-employed individuals. The College appreciates that "health care provider" has been added to the list of stakeholders to be consulted. ACP recommends that the proposed rule be revised to require that "physicians and other health care providers" be consulted by the Exchange. In addition to treating patients, physicians will play a vital role in assisting patients in navigating the new health care landscape; therefore, to help ensure that the Exchange is effectively serving patients and the health care community, physicians should be consulted on an ongoing basis to offer suggestions on issues such as network adequacy standards, patient access to providers (particularly those delivering primary care), among others.

the Exchange ensure it can meet the needs of the population it serves. However, we believe that the categories proposed in §155.130 are broad enough to encapsulate a wide variety of stakeholders, and encourage Exchanges to consult with any other stakeholders that will add perspective to the development of an Exchange. Similarly, we did not accept suggestions to make the stakeholder categories narrower and believe the minimum list proposed will stimulate stakeholder participation. Exchanges have the flexibility to determine what types of stakeholders would fall under each of the categories.	Staff comment: final rule does not specify physician consultation, but Exchanges are permitted to consult physicians.
Transition process for existing State health insurance exchanges (§155.150) Comment: A small number of commenters had suggestions for proposed §155.150(a). A few commenters suggested that we use the Congressional Budget Office estimates for projected coverage in 2016 and others recommended the Census Bureau's American Community Survey or the Current Population Survey estimates of State coverage on January 1, 2010. A number of commenters suggested using a source that included Urban Indian-specific data, while another commenter suggested the coverage numbers be based on non-elderly State residents only. One commenter raised concerns that coverage numbers are calculated inaccurately at the State level. Response: We have amended proposed §155.150(a)(2) to reference the Congressional Budget Office projected coverage numbers published on March 30, 2011. HHS will work with any State that believes it would fall into this category to determine if its State coverage numbers were equal to or above that threshold in January of 2010.	Two health insurance Exchanges that are currently operating were established prior to January 2010, the Utah Health Exchange, which assists small businesses in purchasing health insurance, and Massachusetts' Commonwealth Connector, which serves individuals and small businesses. The College agrees that existing Exchanges should be permitted to continue operation as long as they meet the requirements for Exchanges established in the ACA and subsequent regulations. Further, ACP believes that continued operation should be granted only if the State has insured a percentage of its population equal to or above the percentage of the population projected to be covered nationally following full implementation of the ACA. ACP believes that the qualifying percentage should be no less than the Congressional Budget Office's estimate of the percentage of persons who would have under the ACA's coverage provisions, currently estimated at 95 percent of all legal residents. In addition, the coverage offered to such persons through an existing exchange should be comparable to the coverage (benefits and cost-sharing) required of new exchanges under the ACA. Staff comment: Final rule reflects ACP's recommendation that HHS use CBO estimate of coverage levels.
Financial support for continued operations (§155.160) Comment: Some commenters expressed support for the flexibility provided with respect to funding for ongoing operations as specified in proposed §155.160(b). Others recommended a centralized approach to assessments or raised	ACP policy recommends that Federal grants be allotted to States for the operation of health insurance Exchanges and opposes physician-specific taxes. Therefore, ACP is concerned that the proposed rule recommends levying provider fees to finance Exchange operations after 2015. Health care providers direct a significant portion of

concerns about specific approaches for generating revenue, such as a provider or general tax. A few commenters requested that HHS provide technical assistance to States in developing assessment structures. Response: Exchange flexibility in funding ongoing operations is critical, as we believe that the ability to pursue specific funding strategies may vary by State. We encourage Exchanges to consider the implications of various fee structures on all stakeholders before making a selection, but note that the Exchange has discretion to set parameters related to assessments. As we have noted previously, HHS is committed to working with States on a variety of Exchange features, including but not limited to financial sustainability.	earnings to health care coverage efforts. In FY 2011, 46 States collected fees from physicians and other providers to help fund Medicaid and many other States have established additional fees or taxes on physicians and other providers to raise revenue.[i] Staff comment: Final rule acknowledges concerns regarding provider fees, but does not explicitly prohibit them. Chapters should work with states to develop alternative means of generating funding such as fees on insurers.

[i] National Conference of State Legislatures. Health Care Provider and Industry Taxes/Fees. NCSL. August 16, 2011. Accessed at http://www.ncsl.org/?tabid=14359 on September 16, 2011.