



AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*®

October 24, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9989-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans.*
File Code CMS-9989-P

The American College of Physicians, representing 132,000 internal medicine physician specialists in primary and comprehensive care of adults and adolescents, appreciates the opportunity to provide comments regarding the proposed rule entitled “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans,” issued July 15, 2011.

In 2008, the American College of Physicians (ACP) published the position paper *Achieving Affordable Health Insurance Coverage for All Within Seven Years: A Proposal from America’s Internists, Updated 2008*. In the paper, the College suggested a framework on which policy makers could build a plan to expand health insurance coverage. Among the recommendations, ACP suggested that advanced, refundable tax credits be provided to eligible uninsured individuals to purchase health insurance in State purchasing group arrangements modeled after the Federal Employees Health Benefits Program. Purchasing pool functions would include offering one-stop shopping for group health insurance; limiting participating insurers to those that are able to negotiate bids and terms with providers; providing customers with comparative information on plans; assist in enrolling individuals into plans; collect and process premium payments, and claims costs from year to year; and offer customer service to enrollees. Insurers seeking to offer products in the purchasing group would be required to meet a number of requirements regarding risk rating, guaranteed issuance and renewability, among others.

Additionally, states would be given the option to either operate their own Exchanges, or designate the Federal government (specifically the Office of Personnel Management or its designee) to do so. The health insurance Exchanges established by the Affordable Care Act (ACA) and subsequent regulations have the potential to help individuals and small businesses more easily navigate the complex health

insurance system; standardize essential benefits and consumer protections; and facilitate innovative delivery system changes to improve access to evidence based, high quality care.

While the proposed rule on establishment of State Exchanges largely reflects ACP policy, the College respectfully suggests the following:

155.110 – Exchange governing boards must include a practicing physician among the membership. The proposed rule provides that States may elect to establish the Exchange as an independent State government agency or a non-profit organization with a governing board that must adhere to by-laws adopted by the public. The Exchange governing board must consist of members with relevant experience in various aspects of health care. The proposed rule states that governing boards should primarily consist of consumer and small business-oriented members and must not consist of a majority of insurance issuers, agents, brokers, or any other individual licensed to sell health insurance. Further, the rule establishes that a majority of governing board members should have experience in health care delivery systems administration, public health, health policy issues, health care finance, among other areas, and members would have to disclose any conflicts of interest. 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.

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.

155.150 – Transition process for existing State health insurance Exchanges. 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.

155.160 – Financial Support for Continued Operations. 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 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.¹

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 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.

155.205 – Required consumer assistance tools and programs of an Exchange. 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.

155.230 – General Standards for Exchange Notices. 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.

155.420 – Special Enrollment Periods. 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.

155.1050 – Establishment of Exchange network adequacy standards. The College believes it is vital that qualified health plans ensure that enrollees have access to needed physicians who specialize in primary care as well as other specialists. . Patients who lack sufficient access to a regular physician often delay receiving care, potentially exacerbating illnesses in need of treatment. Patients without a regular physician may also be forced to seek routine care in hospital emergency rooms, a less efficient means of receiving

treatment compared with a physician office visit. For those with multiple chronic illnesses, coordinated care provided by a team of physicians and other health care providers with whom they have a relationship is especially important. While College policy does not suggest a specific model for network adequacy standards, ACP urges 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.”

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. Among the recommendations, the College suggests establishing a national health care workforce policy; improving the training, recruitment, and retention of primary care physicians; implementing payment models that reflect the value of primary care; relieving the administrative burdens shouldered by primary care physicians; and facilitating the development, study, and support of new practice models such as the patient-centered medical home.

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 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.

156.225 – Marketing of QHPs. 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.

Conclusion. The American College of Physicians has long supported efforts to make health coverage affordable to all Americans. Health insurance exchanges will help consumers navigate the complex health insurance marketplace by providing understandable, objective information such as plan benefits, cost-sharing requirements, and provider participation. The insurance reforms, information requirements and essential benefit standards established in the ACA will ensure that Exchange-based plans are accessible

and comprehensive. To better serve patients, the College believes that all Exchanges, whether operated by a State or Federal entity, should have a practicing physician among the governing board membership; regularly consult physicians and other stakeholders on a regular basis; ensure that potential plan enrollees are directed to linguistic and culturally competent care that meets their needs; establish strong network adequacy standards that guarantee access to physicians, particularly those in primary care practice; and conduct robust oversight of health plan marketing, among other requirements. The College looks forward to reviewing subsequent proposed rules relevant to the Exchanges.

Sincerely,

A handwritten signature in black ink that reads "Robert M. Centor MD". The signature is written in a cursive, slightly slanted style.

Robert Centor, MD FACP
Chair, Health and Public Policy Committee
American College of Physicians

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.