

Spotlight on the States



Key State Policy Issues for Health Care Reform Implementation
September 2011

Issue Brief #4:

SUMMARY OF KEY PROVISIONS OF A PROPOSED RULE RELATING TO THE ESTABLISHMENT OF EXCHANGES AND QUALIFIED HEALTH PLANS¹

The Affordable Care Act (ACA) establishes state-based competitive virtual marketplaces where individuals and small businesses can purchase health insurance, known as health insurance exchanges.² The Departments of Health and Human Services (HHS), Labor, and the Treasury are all releasing guidance related to Exchanges in several phases. Most recently, HHS released two proposed regulations on the Establishment of Exchanges and Qualified Health Plans and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, which will implement components of the Exchange and health insurance premium stabilization policies in the Affordable Care Act. They were published in the July 15, 2011 Federal Register (76 FR 41866).³ This Spotlight will focus on the proposed rule on the Establishment of Exchanges and Qualified Health Plans, specifically, the key provisions that impact health centers, including the establishment of network adequacy standards, definition of essential community providers, payment of federally qualified health centers by QHPs, and the Navigator program.

According to HHS, this proposed rule:

- sets forth the Federal requirements that States must meet if they elect to establish and operate an Exchange;
- outlines minimum requirements that health insurance issuers must meet to participate in an Exchange and offer qualified health plans (QHPs); and
- provides basic standards that employers must meet to participate in the Small Business Health Options Program (SHOP).

Comments on this proposed Exchange rule are due **September 28, 2011**.

The executive summary clearly states that the intent of this proposed rule is to “afford States substantial discretion in the design and operation of an Exchange”. The rule also gives great deference to QHPs, in particular regarding their provider networks. Further guidance and rules on other aspects

¹ 45 CFR Parts 155 and 156. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Department of Health and Human Services. Proposed Rule.

² [Spotlight on the States #2: Health Insurance Exchanges: Powers and Issues \(NACHC 2010\)](#)

³ <http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf>

of Health Insurance Exchange operations are expected in the future, including issues such as the minimum benefit package and uniform disclosure rules.

Essential Community Providers (§156.235)

Contracting with Essential Community Providers

This section addresses the issues of payment and participation of health centers. The proposed rule requires a QHP issuer to include within the QHP provider network a sufficient number of essential community providers, where available, that serve predominantly low-income, medically-underserved individuals. The rule defines essential community provider as 1) health care providers defined in Section 340B(a)(4) of the PHS Act; and providers described in 1927(c)(1)(D)(i)(IV) of the Act-- essentially covered entities in the 340B drug discount program, which include FQHCs.

HHS considered requiring QHPs to contract with ALL essential community providers in the QHP's service area, but felt that it "may inhibit attempts to use network design to incentivize higher quality, cost-effective care by tiering networks and driving volume towards providers who meet certain quality and value goals". They further note that "sufficiency" could be interpreted to mean that the QHP issuer must *demonstrate* to the Exchange that it has a sufficient number of essential community providers to meet the Exchange's network adequacy standards. ***The rule DOES NOT require that any health plan provide coverage for any specific medical procedure provided by the essential community provider, nor does it require QHPs to contract with any specific type of essential community providers.***

Payment for Essential Community Providers

With regard to the issue of payment for essential community providers and Federally Qualified Health Centers (FQHC), HHS believes that two provisions in the Affordable Care Act may conflict. Specifically, section 1311(c)(2) states that nothing shall be construed to require a QHP to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of the plan. Section 1302(g), on the other hand, requires a QHP issuer to reimburse FQHCs at each facility's Medicaid prospective payment system (PPS) rate. While HHS does not attempt to resolve this conflict in the proposed rule, it suggests two potential approaches for doing so:

1. Require QHP issuers to pay at least the Medicaid PPS rate to each FQHC that participates in the QHP's network;
2. Permit issuers to negotiate mutually agreed upon rates with FQHCs, as long as they are at least equal to the issuers' generally applicable payment rates.

Practical considerations abound for each of these approaches, both for FQHCs and QHP issuers.

HHS seeks comment on four key issues with regard to the essential community provider requirements:

1. How to define a “sufficient number” of essential community providers. They note that states may elect to establish more stringent participation requirements, including a blanket contracting requirement. They also suggest that a potential “safe-harbor” strategy for QHP issuers would be to contract with all or any-willing essential community providers in the QHP service area.
2. Whether to allow an exemption to the essential community provider requirements for integrated delivery network health plans, where services are provided “in house”.
3. The extent to which the definition of essential community provider should include other similar types of providers that serve predominantly low-income, medically underserved populations and furnish the same services as providers referenced in Section 340B(a)(4) of the PHS Act.
4. The issue of FQHC payment and potential approaches for resolving conflicting statutory provisions.

Establishment of Network Adequacy Standards (§ 155.1050 and § 156.230)

The Affordable Care Act requires that HHS establish network adequacy requirements for all health insurance issuers seeking certification to operate as QHPs. The proposed rule offers a broad standard that each Exchange must apply to ensure that each QHP’s provider network offers a sufficient choice of providers for enrollees.⁴ HHS cites the need for network adequacy standards to be “appropriate to each state’s particular geography, demographics, local patterns of care and market conditions”. In addition, the proposed rule requires a QHP to comply with the network adequacy standards established by the exchange, which must be consistent with network adequacy provisions of Section 2702(c) of the Public Health Service (PHS) Act⁵, and includes essential community providers.⁶

HHS seeks comment on two key issues:

1. additional minimal qualitative or quantitative standards for the Exchange to use in evaluating whether the QHP provider networks provide sufficient access to care; and
2. an additional standard requiring that the Exchange ensure that QHPs’ provider networks provide sufficient access to care for all enrollees, including those in medically underserved area.

⁴ § 155.1050

⁵ Section 2702(c) as amended by the ACA provides: (c) SPECIAL RULES FOR NETWORK PLANS.— (1) IN GENERAL.—In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may— (A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and (B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that— (i) it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees, and (ii) it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such. and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals.

⁶ § 156.230

Such a requirement would, according to HHS, protect against a network design that does not serve all enrollees' medical needs.

Navigator Program Standards (§155.210)

Each Exchange must have a consumer assistance function, including a Navigator program, consistent with this section through which it awards grants to eligible public or private entities to carry out specific duties.

An entity that serves as a Navigator must carry out at least the following duties:

- Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about the Exchange;
- Provide information and services in a fair, accurate and impartial manner. Such information must acknowledge other health programs;
- Facilitate enrollment in QHPs;
- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHS Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

To receive a Navigator grant, an entity must –

- Be capable of carrying out at least those duties described in this section (see below);
- Demonstrate to the Exchange that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a QHP;
- Meet any licensing, certification or other standards prescribed by the State or Exchange, if applicable; and
- Not have a conflict of interest during the term of its grant as a Navigator.

The Exchange must include entities from at least two of the following categories for receipt of a Navigator grant:

- Community and consumer-focused nonprofit groups;
- Trade, industry, and professional associations;
- Commercial fishing industry organizations, ranching and farming organizations;

- Chambers of commerce;
- Unions;
- Resource partners of the Small Business Administration;
- Licensed agents and brokers; and
- Other public or private entities that meet the requirements of this section. Other entities may include but are not limited to Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies.

The Exchange must ensure that a Navigator must not –

- Be a health insurance issuer; or
- Receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP.

Funding for Navigator grants may not be from Federal funds received by the State to establish the Exchange. However, if the State chooses to permit or require Navigator activities to address Medicaid and CHIP administrative functions, and such functions are performed under a contract or agreement that specifies a method for identifying costs or expenditures attributable to Medicaid and CHIP activities, the Medicaid or CHIP agencies may claim Federal funding for a share of expenditures incurred for such activities at the administrative Federal financial participation rate described in 42 CFR 433.15 for Medicaid and 42 CFR 457.618 for CHIP.

HHS seeks comments on several issues related to Navigator program standards:

1. Whether HHS should propose additional requirements on Exchanges to make determinations regarding conflicts of interest;
2. Whether it should require that at least one of the two types of entities serving as Navigators include a community and consumer-focused non-profit organization, or whether it should require that Navigator grantees reflect a cross section of stakeholders.
3. The rule would not preclude a Navigator from receiving compensation from health insurance issuers in connection with enrolling individuals, small employers or large employers in **non-QHPs**. HHS seeks comment on this issue and whether there are ways to manage any potential conflicts of interest that might arise.
4. On potential standards to ensure that information made available by Navigators is fair, accurate, and impartial.
5. HHS is considering a requirement that the Exchanges ensure that the Navigator program is operational with services available to consumers no later than the first day of the initial open enrollment period and seeks comment on this timeframe.

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NACHC Mission:

To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.

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