OPM35-11-R-0001
Request for Information: Multi-state Plans Offered through Exchanges
Response submitted by the Alliance of Community Health Plans

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September 6, 2011

Cheryl D. Allen
Contracting Officer
U.S. Office of Personnel Management
Washington, DC
Via E-mail

Re: OPM35-11-R-0001
Request for Information: Multi-state Plans Offered through Exchanges

Dear Ms. Allen:

The Alliance of Community Health Plans is pleased to submit a response to the Request for Information (RFI) on multi-state plans offered through state health exchanges.

ACHP is a national leadership organization representing community-based and regional health plans and provider organizations that collectively provide health care and coverage for more than 16 million Americans, predominantly in the individual and small and mid-sized group markets. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems. Many ACHP members offer coverage through the FEHB program. They have a significant presence in the Medicare Advantage market and many also contract with their states to provide coverage to Medicaid beneficiaries. Member plans share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality.

Please note that ACHP is not a potential contractor under Section 1334 of the Affordable Care Act, but we want to take this opportunity to address key issues on behalf of our member plans. In similar fashion, we have responded to other information requests or proposed rulemaking implementing provisions of the ACA.

ACHP member plans are community-based and regional plans, typically offered in a state or two states and, in some cases, limited to a sub-state region. Even our largest member, Kaiser Permanente, provides coverage in a relatively small number of states. These plans are prepared to meet the ACA requirements for Qualified Health Plans and seek approval to offer coverage in their state exchanges. They are prepared to compete, but that must be on a level playing field. We recognize that the statute provides that multi-state plans contracting with OPM are deemed approved to offer coverage in each state exchange, but we cannot emphasize too strongly that all plans must be subject to the requirements that apply in a particular state. To do otherwise would grant a significant unfair competitive advantage to multi-state plans. We are concerned that the automatic entry into exchanges for OPM-approved multi-state plans would conflict with the "active purchaser" approach that some states are expected to adopt. (California has already done so.) It will be important for the Secretary of HHS and the Director of OPM to address this potential conflict and find a way to ensure that the criteria that apply to state or regionally-based plans under an active purchasing model also apply to multi-state plans.

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There are a number of areas that we would call to OPM's attention that require careful consideration in determining requirements for multi-state plans:

Quality Measures and Rating System

We believe there should be a uniform set of quality measures and uniform rating system that should apply to all plans offered in the exchange. Multi-state plans should be subject to the quality measures and rating system that the Secretary of HHS will develop under the ACA for use by state exchanges. Multi-state plans must be required to report quality measures in each state, rather than nationally, in order for consumers to be able to compare coverage options available in their local area. We recognize that the rating system which the Secretary will develop will have to incorporate a degree of flexibility in the beginning, given different starting points among the states, but it should move towards greater consistency over time. The goal should be a core set of measures applicable to all plans, collected with the same methodology in all states, and a rating system that is uniform nationally.

ACHP has recommended that the rating system should reflect a high bar and not the lowest common denominator. Thresholds for performance should be raised steadily to drive meaningful improvements by all plans offered in the exchange over a several year period. Development of measures that reflect what a health plan brings to quality improvement should be a high priority, including measures of population health, management of care, patient activation, and coordination across providers and settings. We believe that consumers will want to use a rating system that has comparable meaning across products and markets. They should be able to compare a regionally based plan to a multi-state plan using the same set of metrics. Exchanges will play a critical role in making available information on quality measures and ratings, and using other tools, to promote consumer choice of high quality plans.

Risk Adjustment

Multi-state plans should be fully integrated into the processes that will be designed to mitigate adverse selection among plans offered in the exchange. The requirements for risk adjustment, risk corridors, and reinsurance, and the funding assessments that apply to these mechanisms must include multi-state plans. The overall objective is to improve markets and promote competition among all health plans based on quality, service, and price and not on avoidance of risk.

ACHP has discussed with the staff of the Center for Consumer Information and Insurance Oversight (CCIIO) a set of principles and recommendations for development of these risk mitigation mechanisms. We have emphasized the importance of combining both prospective and retrospective risk assessment. Risk assessment that is solely prospective, like the model used in the Medicare Advantage program, will not be sufficiently robust to account for the high level of turnover among coverage options or the types of health conditions, such as maternity and certain high-cost acute episodes, that are more characteristic of the under age 65 population than Medicare beneficiaries. Retrospective risk assessment would address these problems by accounting for each plan's actual enrollment and diagnoses. The need for this type of hybrid methodology will be especially important in the first few years when little information is known about the newly insured population. ACHP believes, however, that a hybrid approach will continue to be necessary in order to account for conditions that are not sufficiently accounted for prospectively.

Standards for Provider Network Adequacy

All health plans offered in an exchange, including multi-state plans, should be subject to the same standards for the adequacy of their provider network. These standards ensure that the supply, mix, and location of health care professionals and health care facilities are sufficient to provide covered health

services to their members. In establishing these network arrangements, health plans must assure reasonable access to quality primary and specialty care while promoting affordability of care and coverage. Health plans must be able to select those providers that offer the greatest value to plan members based on their performance on dimensions of quality, service and affordability, in sufficient numbers and locations to meet member health care needs.

Historically, it has been the role of states to assure network adequacy by establishing standards in this area. Many states have adopted specific network adequacy standards based on the Managed Care Plan Network Adequacy Model Act ("the Model Act") developed by the National Association of Insurance Commissioners (NAIC). The Model Act requires that plans maintain a provider network that is "sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay." Criteria that may be considered to determine an adequate network include: provider coverage ratios, geographic accessibility metrics, waiting times for appointments with participating providers, hours of operation, and the volume of services available in an area.

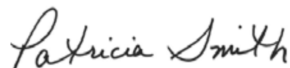
Appropriate regulatory oversight of network adequacy should be in place to assure that plans offering coverage in the exchange are meeting their obligations. Given differences among populations, population distribution, geography, and other factors, ACHP believes that standards for network adequacy should primarily be determined by the states. Our recommendation is that plans meeting state standards for network adequacy of the type provided for in the NAIC Model Act should be judged to have met standards for participation in an exchange. We believe it would be appropriate for the Secretary to require that states which have not adopted specific standards do so within a reasonable period of time. Until those states adopt standards, there are several options for interim requirements, including looking to existing network adequacy requirements under programs such as Medicare Advantage and the FEHBP or those set by accreditation agencies.

State Premium Taxes

It is essential that multi-state plans be subject to state premium taxes and other state and local assessments and fees that apply to all Qualified Health Plans offering coverage in the exchange. This speaks, of course, to the issue of competitive advantage. As you know, premium taxes vary significantly across the states, from zero to over 5 percent, and even vary within a state depending on type of product. We urge OPM to clarify in its procurement documents or other materials that multi-state plans will be subject all state and local taxes, assessments, and fees.

Thank you for consideration of these comments. Please let me or Howard Shapiro (hshapiro@achp.org), our Director of Public Policy, know if we can provide any clarification of these comments.

Sincerely,



Patricia Smith
President and CEO