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### Rural Health Panel

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National Healthcare Operations

Healthcare and Insurance

U.S. Office of Personnel Management

1900 E Street NW, Room 2347

Washington, DC 20415

By electronic submission at <http://www.regulations.gov>

Re: 45 CFR Part 800: Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges

To Whom it May Concern:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased to offer comments regarding the Office of Personnel Management's Notice of Proposed Rulemaking for implementing the Multi-State Plan Program for the Affordable Insurance Exchanges consistent with Title I of the Affordable Care Act.

The Panel understands that OPM will receive comprehensive comments from a wide variety of sources. Thus we limit our comments to rural-specific issues.

#### ACA statute

#1 Section 1334 (c)(1) Among the requirements for MSPs, a multi-state qualified health plan must: offer a benefit package uniform in each state that consists of essential benefits; meet all requirements of a qualified health plan including providing bronze, silver, and gold levels of coverage along with catastrophic coverage.

**PROPOSED RULE:** Proposed §800.109 requires MSPs to fulfill network adequacy criteria, including: maintaining a network comprised of a sufficient number and types of providers to assure that all services will be accessible without unreasonable delay; complying with the adequacy standards of section 2702(c) of the Public Health Service Act; ensuring inclusion of essential community providers; and developing a provider directory for online publication for the Exchange. OPM will provide guidance on criteria and standards used in determining provider network adequacy.

**COMMENT:** Access to health care services and provider types vary among rural areas. In many cases, the provider type that is available in an urban area may not be accessible in a rural area or from one rural area to the next. The network adequacy standards used by CMS to assess Medicare Advantage (MA) plans may

serve as an appropriate model for the MSP network adequacy criteria while meeting the healthcare needs of rural communities.

The flexibility the guidance to MA plans offers for physician categories allows for adjustments for different provider types that can perform the same service. The guidance includes protections of minimum access standards; a plan that fails to meet the minimum number of providers cannot remain in the MA program after the adjustments unless the plan shows that they've contracted with everyone available in the service area.

The Panel recommends that the OPM develop guidance on criteria and standards that parallel the CMS guidance issued for MA plans.

#### ACA statute

#2 Section 1334 (c)(1)(D) of the Affordable Care Act: Requirements for Multi-State Qualified Health Plan: The issuer offers the plan in all geographic regions, and in all States that have adopted adjusted community rating before the date of enactment of this Act.

Section 1334 (5)(e) Application of Certain State Rating Requirements: Phase-in  
Notwithstanding paragraphs (1) and (2) of subsection (b), the Director shall enter into a contract with a health insurance issuer for the offering of a multi-state qualified health plan if with respect to the first year for which the issuer offers such plan, such issuer offers the plan in at least 60 percent of the States;  
2) with respect to the second such year, such issuer offers the plan in at least 70 percent of the States;  
3) with respect to the third such year, such issuer offers the plan in at least 85 percent of the States; and  
4) with respect to each subsequent year, such issuer offers the plan in all States.

**PROPOSED RULE:** Proposed §800.110 essentially requires MSPP issuers to comply with the service areas defined by the Exchanges, but it doesn't require the MSP to be offered in all defined service areas. This rule also establishes phase-in periods in which issuers must provide coverage according to the coverage schedule (1<sup>st</sup> year requires 60 percent coverage of the state; 2<sup>nd</sup> year requires 70 percent coverage of the state; 3<sup>rd</sup> year requires 85 percent coverage of the state; and 100 percent coverage of a state by the 4<sup>th</sup> year and subsequent years). If issuers can only offer coverage in a portion of a service area during the phase-in year OPM will permit an exception so long as the issuer submits a plan for future entire-state coverage. This ultimately allows for partial county service area coverage.

**COMMENT:** Proposed §800.110 provides an opportunity to encourage the spread of competing health plans into rural areas by virtue of allowing them flexibility to incrementally achieve statewide coverage. Conversely, allowing health plans to operate in only some parts of states and/or counties coverage may enable them to systematically select coverage areas that might disadvantage rural residents if unattractive markets (based on population density, negotiating power of local providers, and/or population health status characteristics/costs) would be disproportionately rural. The Panel recommends that a Plan not be allowed to operate in a given state until it is able to offer all residents of the state access to the plan, including meeting network adequacy standards throughout the state. This rollout is consistent with Section A with the phase-in schedule in that MSPs have to be in all states providing coverage to the entire geographic area of all states by year four. Offering a multi-state plan in the whole state enables rural residents access to these plans and further supports robust competition in the Exchanges.

Sincerely,

The Rural Policy Research Institute Health Panel

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