



2016 Notice of Benefit Payment and Parameters, Final Rule

On February 20, 2015, CMS released the 2016 Benefit and Payment Parameters final rule. The final rule establishes new requirements for qualified health plans related to prescription drug formularies, provider directories, and essential health benefits, among others. While the final rule addresses a number of ACP concerns, the agency decided against revising the provider network adequacy rules. The agency states that it is waiting for the NAIC network adequacy model act to be finalized before proposing major changes to the QHP network adequacy requirements. The NAIC is still in the process of developing the revised model act. According to the NAIC Subgroup working on the revision, it “intends to complete its work with revising Model #74 either at or prior to the Summer National Meeting.”

Other points of interest to ACP include:

- **Annual Eligibility Redetermination:** The proposed rule considered automatically enrolling individuals in a lower premium plan during open enrollment. ACP and others expressed concern that this policy may confuse consumers and that premium level is not the only plan characteristic important to enrollees. The agency did not adopt the policy in the final rule.
- **Special Enrollment Period:** ACP recommended that a special enrollment period be granted to people if they enrolled in a QHP with an inaccurate provider directory and their preferred provider was not actually included in the network. While the agency did not designate such an enrollment period, the final rule does acknowledge ACP’s inquiry on whether an inaccurate directory would qualify as a contract violation and trigger an SEP, “(CMS) notes that consumers may be determined eligible for the special enrollment period provided in paragraph (d)(5) of this section if an issuer substantially violates their contract with the enrollee.” ACP may want to seek further clarification on how this would work in practice.
- **Prescription Drug Coverage:** The rule finalizes a proposal that P&T committees (with practicing physicians among the membership) would review QHP formularies to ensure safety and efficacy and not just cost are considered. The rule maintains the existing USP drug count standard. The P&T committee policy was applauded by ACP and consumer groups and should help to bring evidence-based oversight into the formulary development process. The final rule also incorporates a requirement that QHPs have a “standard exception process” to allow enrollees to access medically necessary, off-formulary drugs; decisions on such appeals would have to be made within 72 hours. ACP recommended a similar process in its 2014 SNHC letter to HHS and supported the proposal in this rule.
- **Network Adequacy/Provider Directories:** While the final rule does not make major changes to the adequacy requirements, it does mandate that QHPs closely monitor their provider directories and update them at least monthly. It also specifies what information should be included in directories. Inaccurate provider directories have been a major problem, and

hopefully by strengthening oversight, consumers will be able to ensure that their preferred provider participates in their QHP.

The final rule can be access [here](#). A summary of the rule is available [here](#).

Final Rule Comments/Response

ACP Comments

<u>155.335: Annual Eligibility Redetermination</u>	<u>155.335: Annual Eligibility Redetermination</u>
<p>Comment: We received many comments regarding the proposed alternative re-enrollment hierarchies. Commenters who opposed permitting alternative enrollment hierarchies, particularly those that prioritize low-premium plans, noted that, in most cases, the plan a consumer chooses during open enrollment is one that the consumer has shopped for and has determined best meets his or her needs. Additionally, commenters highlighted that low-cost premiums do not necessarily lead to lower overall cost of coverage because deductibles, copayments, coinsurance, and out-of-pocket limits may be higher.</p> <p>Response: We appreciate the many comments received regarding alternative re-enrollment hierarchies and are sensitive to the concerns raised by commenters. Consumers consider many factors when selecting health coverage in addition to the premium, including the provider network, cost-sharing, deductibles, and other factors which affect overall costs, continuity of care, and the consumer experience.</p> <p>At the same time, we continue to believe that default re-enrollment of consumers in the same plan (or a similar plan) may not best serve consumers' interests in cases where the premium for their plan relative to available alternatives has changes substantially. Due to concerns expressed by commenters, we are not finalizing changes to the re-enrollment hierarchies. Instead, the existing re-enrollment hierarchies will remain in place. In accordance with commenters' suggestions, we may revisit alternative</p>	<p>While it is sensible to encourage qualified health plan (QHP) enrollees to shop around for the plan that best meets their insurance needs and financial situation, ACP is concerned that automatically transferring an enrollee to a cheaper plan could create problems. A lower-cost plan could have a narrow provider network and not include an enrollee's preferred physician or hospital. While premiums may be lower, deductibles, coinsurance, and copayments may be higher than in the enrollee's previous plan. Formularies may also differ. Many health insurance consumers have limited health insurance literacy and abruptly switching a person to a new plan with a different structure could be very confusing. While the price of health insurance is important, consumers value other health plan characteristics, including provider networks. The College urges caution in implementing automatic re-enrollment policies, even if an enrollee chooses the lowest cost plan re-enrollment option. If the agency pursues this option, efforts should be made to educate the enrollee in advance of default re-enrollment on potential changes to plan structure, cost-sharing, provider networks, and formularies, and highlight the opportunity to switch plans during open enrollment if they prefer.</p> <p>Staff comment: The final rule acknowledges the concerns of ACP and others that automatic re-enrollment may have unintended consequences. The rule mentions that enrollees may be enrolled in lower-premium plans, but face higher cost-sharing that may discourage receipt of necessary care. It appears that the agency will continue to study ways to improve the re-enrollment process,</p>

<p>hierarchies as we learn more about consumer preferences and gain implementation experience.</p>	<p>so ACP should keep an eye on future changes.</p>
<p><u>155.420: Special Enrollment Periods</u></p> <p><u>Comment:</u> Several commenters requested that HHS include additional special enrollment periods pertaining to provider networks, specifically when a consumer enrolls in a qualified health plan with an inaccurate provider directory, enrolls in a plan which changes their health plan’s provider or pharmacy networks mid-year, or enrolls in a plan with no in-network providers within a 25 mile radius of the consumer.</p> <p><u>Response:</u> Response: We acknowledge the need for consumers to have access to correct information about their QHPs and participating providers and pharmacies, and have promulgated provisions pertaining to the maintenance and dissemination of provider and pharmacy directories in this rule. However, provider and pharmacy network participation changes frequently.</p> <p>Therefore, determining who would be eligible for the type of special enrollment period suggested by commenters would require that issuers report to the Exchange whenever provider and pharmacy network participation changes and that the Exchange notify consumers potentially impacted by such changes. As such, we are not making changes in response to these comments, and note that consumers may be determined eligible for the special enrollment period provided in paragraph (d)(5) of this section if an issuer substantially violates their contract with the enrollee.</p>	<p><u>155.420: Special Enrollment Periods</u></p> <p>ACP reiterates our recommendationⁱⁱ that a special enrollment period be triggered to allow patients to choose another QHP if an outdated network directory has incorrectly listed an enrollee’s preferred physician as being part of the network. We ask the agency to clarify if this would be permitted under 45 CFR 155.420(d)(5), which states that a special enrollment period may be triggered if “(a)n enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.”</p> <p><u>Staff comment:</u> While it is disappointing that the final rule did not establish a special enrollment period trigger if enrollees enroll in a plan with an inaccurate provider directory, it is encouraging that the rule addresses ACP’s query on whether a special enrollment period could be triggered based on the “contract violation” provision, potentially giving enrollees a means to switch plans because their preferred physician was listed in the plan’s provider directory in error. ACP may want to follow up with CMS to ask how “substantially violates their contract with the enrollee” would be determined.</p>
<p><u>156.115: Provision of EHB</u></p> <p><u>Comment:</u> Some commenters expressed their desire for HHS to abandon the benchmark policy in the future, and specify a list of services that issuers must cover in each EHB category instead.</p> <p><u>Response:</u> To maintain State flexibility while ensuring comprehensive coverage, we</p>	<p><u>156.115: Provision of EHB</u></p> <p>ACP supports the proposal to allow states to update their benchmark plans as well as the requirement to collect and report essential health benefit data. ACP strongly supports a robust essential health benefit package that includes prevention and wellness services and chronic disease management. We urge CMS to work with states to gather data and guide QHPs to ensure</p>

<p>believe that the benchmark policy continues to be the most appropriate at this time. Therefore, the benchmark policy will continue to establish EHBS through plan year 2017. Since the first EHB plan year just ended, we will examine how the policy affected enrollees and what changes, if any, should be made in the future. We believe that it is important to have a more complete sense of how EHB policy is working before proposing changes to the benchmark approach.</p>	<p>they provide coverage proven to be effective in reducing obesity, stopping smoking, deterring alcohol abuse, and promoting wellness, among other goals. We continue to support requirements that QHPs cover preventive services without cost sharing, including those supported by the United States Preventive Services Task Force. <u>Staff comments:</u> Unsurprisingly, the final rule continues the benchmark policy through PY 2017. The final rule also establishes a definition for habilitative services and requires issuers to have separate visit limits for habilitative and rehabilitative services.</p>
<p><u>156.122: Prescription Drug Benefits</u></p> <p><u>Drug Counts and P&T Committees</u></p> <p>We are retaining the USP drug count standard because stakeholders are now familiar with the USP system after using it for 2 years, and we were persuaded by the comments supporting the continued use of USP.</p> <p>Based on comments received, as described in detail below, we are finalizing an approach that combines the use of a P&T committee (satisfying standards largely as proposed) with the current drug count standard that requires coverage of at least the greater of one drug per USP category and class or the same number of drugs in each USP category and class as the State's EHB benchmark plan. P&T committees must be established beginning in the 2017 plan year.</p> <p><u>Comments:</u> Several commenters supported combining the P&T committee with a drug count standard. Of those who commented on the drug count standard, some supported USP, some supported AHFS, and others supported the creation of a new standard.</p> <p><u>Response:</u> We are finalizing an approach that combines the use of a P&T committee with the current drug count standard that requires coverage of at least the greater of one drug per USP category and class or the same number of drugs in each USP category and class as the</p>	<p><u>156.122: Prescription Drug Benefits</u></p> <p>ACP is supportive of the agency's proposal to improve oversight of QHP prescription drug benefits and ensure that enrollees can access safe and effective medications. Although the College does not have policy on the existing US Pharmacopeia (USP) drug count system, we are concerned that current requirements are insufficient and unwieldy for patients, physicians and other health care professionals, and issuers. Requiring QHPs to establish objective pharmacy and therapeutic (P&T) committees that include practicing physicians (such as internists) among the membership will help to ensure that QHPs make formulary decisions based on a drug's safety and efficacy, not just its cost and facilitate consideration of new FDA-approved drugs as well as new uses of existing drugs. At a minimum, an improved drug count requirement working in concert with the P&T committee recommendations could relieve concern about the existing formulary requirements. ACP provides the following guidelines on formulary development...</p> <p>ACP believes that there must be a process for expedited prescription drug coverage exceptions and appeals. The final rule should mandate that insurers and independent review entities provide a decision to the patient and provider, prescriber, etc. within 24 hours for exigent health situations or 72 hours for non-exigent situations. The College applauds the proposed standard exception process (156.122(c)(1)) for disputed prescription drugs as</p>

State's EHB benchmark plan. We believe that a combination of a qualitative and quantitative approach will best ensure robust formulary design, because the two standards can complement each other. For instance, the requirement of the P&T committee to review new drugs addresses one of our concerns that the current drug count system does not incentivize coverage of new drugs. However, the drug count standard can provide a minimum standard for coverage.

We do not believe that enrollees should have to continue to make requests under §156.122(c) to access a refill of the same clinically appropriate drugs that they initially obtained through the exceptions process. Therefore, we are finalizing a standard under which non-grandfathered health plans in the individual and small group markets that must provide coverage of the essential health benefit package under section 1302(a) of the Affordable Care Act must cover a drug accessed through the standard exception process for the duration of the prescription, including refills.

Issuers will be required to comply with the new standard exception process and external review process requirements starting with the 2016 plan year.

Other provisions (temporary fills, preventive drugs)

In addition to the proposed provisions above, we urged issuers to temporarily cover non-formulary drugs (including drugs that are on an issuer's formulary but require prior authorization or step therapy) as if they were on formulary (or without imposing prior authorization or step therapy requirements) during the first 30 days of coverage. We encouraged plans to adopt this policy to accommodate the immediate needs of enrollees, while allowing the enrollee sufficient time to go through the prior authorization or drug exception processes.

Comment: Some commenters sought clarification

well as the expedited exceptions process for exigent circumstances. These changes will help to ensure our patients can receive necessary drugs prescribed by their physician without delay. QHPs should allow patients to continue to receive disputed medication during an entire exception review process, and if an exception is granted, continue to provide coverage for the exception drug during subsequent plan years.

Staff Comment: A number of positive reforms are established in the final rule. While the controversial USP drug count standard remains, issuers are required to have Pharmacy and Therapeutics Committees which are required to have practicing physicians among the membership. The P&T committee will be able to ensure new drugs are included in plan formularies and determine if formularies are constructed based on safety and efficacy and not just cost. P&T Committees are obligated to conduct a review of clinical appropriateness of prior authorization requirements, utilization review, and other requirements that affect access. Note that issuers will be obligated to

The final rule codifies the standard exception process, where an enrollee and/or their physicians could request coverage of a clinically appropriate drug that was not on the plan's formulary; a decision on the exception must be made within 72 hours. ACP has recommended such an exception process on a number of occasions.

Unfortunately the final rule maintains that the government "encourages" but does not require plans to cover 30-day transitional prescription fills for new enrollees. ACP should continue to advocate that this be a requirement of all QHPs.

about coverage of medical drugs and preventive service drugs. Others recommended requiring limits to formulary changes during the plan year. Several commenters recommended that we require issuers to temporarily cover non-formulary drugs during the first 30 days of coverage or longer and other commenters were against this policy, stating that it is not a typical requirement in the private market, and that it is costly and counterintuitive to formulary transparency. Other commenters supported transition policies, but acknowledged the importance of flexibility for issuers in developing these policies.

Response: Preventive services, including preventive service drugs, are required to be covered as part of EHB. Non-grandfathered group health plans and health insurance coverage must provide benefits for preventive health services, including preventive service drugs, without cost sharing, consistent with the requirements of section 2713. Similarly, the rules set forth under §156.122 are specific to coverage of drugs under the prescription drug EHB category. Issuers could cover drugs administered as part of another service (such as during an inpatient hospitalization or a physician service) under the EHB category that covers that service, in addition to covering the drug under the prescription drug EHB category. We believe this clarification reflects the current practice of issuers. We are also concerned about issuers making mid-year formulary changes, especially changes that negatively affect enrollees.

We are monitoring this issue to consider whether further standards are needed. We also note that, under guaranteed renewability requirements and the definitions of “product” and “plan,” issuers generally may not make plan design changes, including changes to drug formularies, other than at the time of plan renewal. We recognize that certain mid-year changes to drug formularies related to the availability of drugs in the market may be necessary and appropriate.

We are not requiring coverage of a transitional fill at this time. As stated in the proposed rule, we will

<p>consider whether additional requirements may be needed in this area. We remain concerned that new enrollees may be unfamiliar with what is covered on their new plan’s formulary drug list and the process and procedures under the plan. Further, some new enrollees whose drugs are covered by the plan’s formulary may need to obtain prior authorization or go through step therapy to have coverage for their drugs, and others may need time to work with their provider to determine which formulary drug the individual should be transitioned to. For these reasons, we urge issuers to temporarily fill drugs that are not on the formulary (or are on an issuer’s formulary but require prior authorization or step therapy) as if they were on formulary (or without imposing prior authorization or step therapy requirements) during the first 30 days of coverage.</p> <p>We encourage plans to adopt this policy to accommodate the immediate needs of enrollees, while allowing the enrollee sufficient time to go through the prior authorization or drug exception processes.</p>	
<p><u>156.125: Prohibition on Discrimination</u></p> <p>In this final rule, CMS adopts the same approach as described in the proposed rule. As we indicated in the proposed rule and the 2014 Letter to Issuers, we will notify an issuer when we see an indication of a reduction in the generosity of a benefit in some manner for subsets of individuals that is not based on clinically indicated, reasonable medical management practices. We conduct this examination whenever a plan subject to the EHB requirement reduces benefits for a particular group. Issuers are expected to impose limitations and exclusions based on clinical guidelines and medical evidence, and are expected to use reasonable medical management. Issuers may be asked to submit justification with supporting documentation to HHS or the State explaining how the plan design is not discriminatory.</p> <p><u>Comment:</u> Some commenters expressed concern regarding the example of placing most or all drugs</p>	<p><u>156.125: Prohibition on Discrimination</u></p> <p>ACP is very concerned that some QHPs are designing plans that may discriminate against some patients, including those with multiple chronic health conditions. We urge that Federal and state regulators and other stakeholders closely monitor formularies and other benefit design features to ensure that coverage does not exclude patients with complex chronic conditions, including patients with cancer, transplants, mental health treatment, HIV/AIDS, and hepatitis C. Such limited formularies and plan restrictions would violate the spirit of the ACA’s nondiscrimination provisions which prohibit discrimination based on factors including health status, disability, age, race, gender, and sexual orientation. The College appreciates that the proposed rule acknowledges this concern and admonishes issuers to design plans that reflect the non-discrimination requirements of the law. We support language that would prevent the discriminatory age limits on effective benefits as</p>

<p>for a certain condition on a high cost tier. They noted that drug tiering reflects current realities of the drug market and is based on costs. The commenters asked CMS to clarify that having a specialty tier is not discriminatory.</p> <p><u>Response:</u> The examples provided in the proposed rule are potentially discriminatory if there is no appropriate non-discriminatory reason for the noted practice. Having a specialty tier is not on its face discriminatory; however, placing most or all drugs for a certain condition on a high cost tier without regard to the actual cost the issuer pays for the drug may often be discriminatory in application when looking at the totality of the circumstances, and therefore prohibited. When CMS or the State requests a justification for such a practice, issuers should be able to identify an appropriate non-discriminatory reason that supports their benefit design, including their formulary design.</p>	<p>well as prohibitions on plan designs that would discourage enrollment of patients with chronic health needs. Moreover, we strongly urge CMS to enforce non-discrimination requirements.</p> <p><u>Staff comment:</u> The attention given to placing drugs for certain conditions in a high-tier is valid. A recent Avalere study found that many QHPs placed all drugs for certain conditions like MS and HIV in the high-cost specialty tier, making them financially out-of-reach for many enrollees.</p>
<p><u>156.145: Determination of Minimal Value</u></p> <p>Employer-sponsored plans in the large group market and self-insured employers continue to have flexibility in designing their plans. They are not required to cover all EHB. Providing flexibility, however, does not mean that these plans can offer whatever benefits they choose and automatically meet MV requirements. A plan that excludes substantial coverage for inpatient hospital and physician services is not a health plan in any meaningful sense and is contrary to the purpose of the MV requirement to ensure that an employer-sponsored plan, while not required to cover all EHB, nonetheless must offer coverage with minimum value at least roughly comparable to that of a bronze plan offered on an Exchange. ...</p> <p>We are not requiring that large employer or self-insured employer group health plans provide all EHB as defined under section 1302 of the Affordable Care Act. Rather, we are only requiring that, to provide MV, employer-sponsored plans provide substantial coverage of</p>	<p><u>156.145: Determination of Minimal Value</u></p> <p>ACP supports this provision, which would codify the requirement that employer-sponsored plans must provide coverage of inpatient hospitalization and physician services to meet minimum value requirements. This policy will ensure that enrollees can access crucial services that form the core of health insurance plans.</p>

<p>the two types of benefits that we believe were envisioned for health plan coverage meeting the MV standard. We have concluded that plans that omit these types of coverage fail to meet universally accepted minimum standards of value expected from, and inherent in the nature of, any arrangement that can reasonably be called a health plan intended to provide the primary health coverage for employees.</p>	
<p><u>156.230: Network Adequacy</u></p> <p>We believe that networks that provide sufficient access to benefits are a priority for issuers and consumers. HHS continues to take great interest in ensuring strong network access, particularly for QHPs that must meet the standards in §156.230. As stated in the proposed rule, HHS is aware that the NAIC has formed a workgroup that is drafting a model act relative to network adequacy and will await the results of this workgroup before proposing significant changes to network adequacy policy.</p> <p>For 2016, HHS expects to continue the reasonable access standard adopted in the 2015 Letter to Issuers in the Federally-facilitated Marketplaces and assess the provider networks information submitted as part of the QHP certification process. We urge State-based Exchanges to employ the same standard when examining network adequacy.</p> <p>In addition to the changes above, we are also cognizant that new enrollees in QHPs may need a transition period to switch to a provider that is in-network in their new plan. We encourage QHP issuers that use a network of providers to offer new enrollees transitional care for an ongoing course of treatment. We suggest that this begin with the effective date of coverage of a new enrollee and last for at least 29 days thereafter (for a minimum of 30 days).</p> <p>These benefits would extend to health care services furnished by any provider to the new enrollee, regardless of whether the provider is in the plan’s network, as long as the enrollee</p>	<p><u>156.230: Network Adequacy</u></p> <p>ACP remains concerned that many QHPs continue to offer narrow network (including tiered network plans) in an effort to hold down costs. The College acknowledges that in the 2015 letter to federally-facilitated marketplace issuersⁱ, CMS outlined its intent to assess provider networks using a “reasonable access” standard, identify plans that fail to meet this standard, and apply particular scrutiny to areas that have historically raised network adequacy concerns, including primary care providers. The rule proposes continuing this standard in the 2016 plan year while acknowledging that the National Association of Insurance Commissioners (NAIC) is in the process of updating its Managed Care Plan Network Adequacy Model Act (Model Act). Since the NAIC’s updated Model Act may recommend significant changes, ACP requests that in its final rule, CMS outline a schedule for considering, and, if necessary, updating the network adequacy standards based on the revised NAIC Model Act. ACP reiterates its recommendations to HHSⁱⁱ on network adequacy standards, including:</p> <ul style="list-style-type: none"> • That CMS improve current network adequacy standards by taking into account additional quantitative criteria—including patient-to-physician ratios, maximum travel time and distance, and provider capacity standards—as indicators of access. CMS should work closely with state regulators to address network adequacy concerns that are most relevant to each state (and the individual health plan service areas within each state).

received health services from that provider under an ongoing course of treatment in the 90 days prior to the effective date of coverage. Because different plans may have different provider networks, when an individual enrolls in a new health plan, he or she may be undergoing a course of treatment with a provider that is not in the new issuer's provider network. In such a case, it may take time for the new enrollee to select a new in-network provider and to meet with the new provider to ensure that there is no disruption in treatment. We encourage issuers to adopt this policy to accommodate the immediate needs of enrollees, while allowing the enrollee sufficient time to go through the process of selecting an in-network provider in their new plan. As we stated in the proposed rule, we are considering whether requirements may be needed in this area in the future.

We are renumbering §156.230(b), to (b)(1) and adding (b)(2) to strengthen the provider directory requirement effective for plan years beginning on or after January 1, 2016. Specifically, we proposed that a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, and OPM. As part of this requirement, we proposed that a QHP issuer must update the directory information at least once a month, and that a provider directory will be considered easily accessible when the general public is able to view all of the current providers for a plan on the plan's public website through a clearly identifiable link or tab without having to create or access an account or enter a policy number.

The general public should be able to easily discern which providers participate in which plan(s) and provider network(s) if the health plan issuer maintains multiple provider networks, and the plan(s) and provider network(s) associated with each provider, including the tier in which the

- Continuously monitor network adequacy by complaint tracking and random spot checks of QHP network data.ⁱⁱⁱ We recommend that such compliance and complaint information be made available to the public.
- Require transparency in the criteria used by QHPs to determine who will be allowed into networks. QHPs should consider multiple criteria related to professional competency, quality of care, and the appropriate utilization of resources. In general, no single criterion – including cost - should provide the sole basis for selecting or excluding a physician from a plan's network.
- In keeping with nondiscrimination guidelines, QHPs should be prohibited from excluding health care clinicians whose practices contain substantial numbers of patients with expensive medical conditions.
- Network adequacy requirements should be strictly enforced.

ACP supports the proposed rule's requirement that provider directories be up-to-date, accurate, and complete and, at a minimum, include the provider information specified in the rule. Online provider directories should be updated at least monthly. The College reiterates its support for the development of an online search tool to allow federally-facilitated marketplace users to search for QHPs by clinician and hospital name and filter out health plans that do not include the consumer's chosen clinician or hospital in network. Requiring QHP issuers to provide network data in machine-readable format may facilitate the development of such tools by third-party entities; however, this should not substitute the agency's work to develop tools to improve the consumer shopping experience.

ACP requests adoption of the continuity of care provisions that would allow an out-of-network physician to continue treatment of a patient regardless of network status during the first 30

provider is included, should be clearly identified on the website and in the provider directory. We solicited comments on this proposal, including comments regarding how often updating should occur. We are finalizing this policy as proposed, retaining the monthly timeline.

We also finalize the requirement for issuers to make this information publicly available on their websites in a machine-readable file and format specified by HHS. The purpose of establishing machine-readable files with this data would be to provide the opportunity for third parties to create resources that aggregate information on different plans. We believe this will increase transparency by allowing software developers to access this information and create innovative and informative tools to help enrollees better understand the availability of providers in a specific plan. To facilitate this change, we proposed adding §156.230(c) to require QHP issuers to make available and submit to HHS information about providers in its provider networks.

Comment: A number of commenters supported stronger network adequacy standards.

Commenters were divided between supporting our proposal to wait for NAIC recommendations before taking further action, and urging us to act immediately and implement stronger network adequacy standards. Commenters suggested a wide range of network adequacy criteria for HHS to adopt, including provider to patient ratios; time and distance metrics; geographic-based metrics; minimum numbers of specialty providers; specific criteria for areas of concern including pediatric, dialysis centers, and autoimmune and rare disorders; monitoring of plans; and secret shopping. One commenter requested increased transparency regarding evaluation of network adequacy. This commenter suggested that HHS should modify the provider data template for QHP issuers in the FFEs to allow greater flexibility, and should clarify how reasonable access will be determined in situations where a sufficient number of providers are not willing to contract with the issuer.

days following enrollment in a new QHP. ACP supports language that would require issuers to count out-of-network cost-sharing toward the annual out-of-pocket limit. While the language in 156.130 would make this optional, the College requests that at a minimum, out-of-network cost-sharing for care received when appropriate physicians (i.e. subspecialists) or services are not offered in the plan's existing network be applied to the annual limitation on cost sharing.

Staff Comments: The final rule maintains the reasonable access standard established in the 2015 Letter to Insurers. It mentions that the NAIC is updating the Model Act, but does not specify when it will consider updating its network adequacy rules based on the revised NAIC model. It may be months before the NAIC model is finalized and additional months before states begin revising their network adequacy requirements.

Once again, the rule encourages but does not require that insurers cover care provided by an enrollee's current provider for 30 days after transitioning to the new plan. ACP has asked HHS to make this a requirement of QHPs.

Perhaps the most promising development is the new requirements on provider directories. Issuers are required to update directories at least once a month and provide specific information. The rule also establishes accessibility criteria. The agency comments state that issuers are encouraged (but not required) to honor provider directories even if they are inaccurate.

Response: We are finalizing the rule without making any additional changes to the network adequacy general requirements at this point as the NAIC finishes its work on the network adequacy model act. We expect that the final product of the NAIC work will reflect the viewpoints of the various stakeholders. This reflects our general position that network adequacy is an area subject to significant State regulation and oversight.

We agree with commenters that QHP networks should provide access to a range of health care providers, and we continue to require all QHP issuers to provide reasonable access to all covered services in accordance with §156.230(a) of this rule. We are also planning changes to the template used to collect network data to improve the collection process for QHP issuers in the FFE during the QHP certification process.

Comment: A number of commenters support the clarification that only in-network providers will be considered when determining if a plan's medical network meets reasonable access requirements, and urged CMS to clarify that issuers must be able to provide reasonable access with the providers available in their lowest cost tier. Other commenters also urged CMS to require issuers to have an internal exceptions or appeals process to obtain out-of-network services at in-network cost when adequate access is not available, while others stressed that out-of-network referrals should be rare. Similarly, several commenters voiced concerns about consumers being charged out-of-network charges while being treated in an in-network hospital because not all of the treating providers were in-network. In such circumstances, commenters urged that the consumer only be charged in-network costs, and that in-network hospitals should be required to have sufficient in-network providers to furnish all covered services. Some commenters raised concerns about the standard use of out-of-network providers for dental networks and the lack of availability of dentists who will contract with issuers.

Response: In light of the general support of the proposed change, we intend to finalize the regulation as proposed. We understand the concern about confusion created when a hospital is listed as in-network and has providers that are out-of-network for particular in-house services. We remind issuers that all covered services must be reasonably accessible, and in accordance with this regulatory change, must be available in-network. We urge issuers to evaluate their in-network hospitals to make certain that all required services are accessible without unreasonable delay from in-network providers. We appreciate the concerns voiced regarding coverage of dental providers and are contemplating whether further guidance is warranted.

Comment: A number of commenters strongly supported the transition policy allowing new enrollees to have access to providers from whom they received services before they joined their new plan. Some commenters urged HHS to require the transition policies, and some advocated for longer transition periods, such as 60 or 90 days or 6 months with reassessment, to determine if continued care is necessary at the end of the set time period. Some commenters suggested expanding transitional policies to include current enrollees whose in-network providers become out-of-network providers mid-year due to network changes. Conversely, some commenters expressed that clear and accurate provider directories make transitional policies unnecessary, and some believe the policy would negatively impact care management and that many States already have requirements for transitional care. Similarly, some suggested that transitional policies should have specific limits, including specific situations and types of care, to reduce the impact on premiums. Many commenters expressed concern about what payment rates would be if there is no contract with the out-of-network provider and suggested HHS should require plans to reimburse providers the reasonable and customary value for out-of-network services and prohibit balance billing of consumers for anything above what they would have been charged for the services in-network.

Commenters also stated that this is an area that many States already regulate closely.

Response: There are strong opinions supporting and opposing a requirement for a transitional policy, as well as varying opinions about the amount of time transitional policies should cover. We continue to encourage issuers to adopt appropriate transitional policies and to pay close attention to issues around continuity of care for both new enrollees and enrollees whose current providers become unavailable. We expect to continue to analyze this area and may propose standards concerning this topic in the future.

Comment: Commenters generally supported the proposal to strengthen provider directory requirements and agreed that provider data should be updated at least monthly, especially for on-line directories. Some commenters urged more frequent updates and urged CMS to move towards requiring “real time” updates in the future. Concerns were raised about penalizing issuers if there were errors in the directories because providers may fail to notify the issuer of changes, and the administrative burden and costs associated with strengthened provider directory requirements. Conversely, other commenters urged that issuers be required to honor what is listed in the provider directory even if it erroneous, and that plans be required to monitor data for accuracy.

Response:

We are finalizing the regulation as proposed. We are requiring that directories be updated at least monthly and encourage more frequent updating when possible. We also understand and appreciate the concern about issuers being held accountable for errors in directories and encourage issuers to work with their providers to ensure that their directories are as current and accurate as possible. We understand that there may be some administrative burden associated with updating directories, but believe it is necessary for

<p>consumers to be fully informed about network access. Similarly, we appreciate commenters who stated that issuers should honor what is listed in their directories even if there are errors, and while we are not requiring that at this time, we strongly encourage that practice.</p> <p>We are finalizing our proposal requiring the issuer to publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider’s location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, and OPM.</p> <p>Based on the comments received asking us to make provider information more transparent and accessible to consumers, HHS is finalizing this rule by adding §156.230(c), to require QHP issuers in the FFEs to make available the information on the provider list on its website in a HHS specified format and also submit this information to HHS, in a format and at times determined by HHS. We agree with commenters that creating a vehicle for consumers to easily determine which providers are in which networks will help consumers select QHPs that best meet their needs. We recognize that this will require issuer resources, and will provide further details about the specific data elements, frequency of updates, file types, and other crucial information in future guidance.</p>	
<p><u>156.235: Essential Community Providers</u></p> <p>We codify the standard for QHP issuers used in 2015 for the FFMs—that issuers seeking qualified health plan certification in the FFMs subject to the general essential community provider</p>	<p><u>156.235: Essential Community Providers</u></p> <p>The College supports requirements for the inclusion of essential community providers (ECP), such as federally qualified health centers, Ryan White HIV/AIDS providers and safety-net hospitals,</p>

<p>standard will be required to offer provider contracts to: (a) all available Indian health providers in the service area; and (b) at least one essential community provider in each essential community provider category (i.e., Federally Qualified Health Clinics, Ryan White providers, family planning providers, hospitals, and others) in each county in the service area, where a provider in that category is available.</p> <p>We also codified and updated the 2015 FFM policy that provides a percentage threshold for 2016 through HHS guidance, informed by our assessments of the adequacy of essential community provider participation and geographic distribution of such providers.</p> <p>(From summary document found here)</p>	<p>and maintains that the 30% ECP threshold (established in the 2015 letter to FFM issuersⁱ) should be a minimum floor, and QHPs should be encouraged to incorporate additional ECPs to meet the needs of patients in the service area. CMS should closely scrutinize QHP requests for exceptions to this rule and closely monitor plans that are granted exceptions, requiring changes as needed. Contingency plans must prioritize continuity of care with the patient's preferred health care clinician.</p> <p><u>Staff comment:</u> The new regulation is stronger than previous ECP requirements in that the definition has been broadened to include 340B providers that do not receive Federal funding. The rule language states:</p> <p style="padding-left: 40px;">A QHP issuer that uses a provider network must include in its provider network a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards.</p> <p>QHPs are required to cover a minimum percentage of ECPs in a plan area. The percentage for the 2016 plan year will be released in future regulation. The rule also clarifies that to be considered an ECP, a provider must serve low-income, medically underserved population and not simply be located in a low-income area.</p>
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ⁱ Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services. 2015 Letter to Issuers in the Federally-facilitated Marketplaces. March 14, 2014. Accessed at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>

ⁱⁱ American College of Physicians. Letter to the Honorable Kathleen Sebelius. February 11, 2014. Accessed at http://www.acponline.org/acp_policy/letters/sebelius_letter_snhc_2014.pdf

ⁱⁱⁱ Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services. Affordable Exchanges Guidance: Letter Issuers on Federally-facilitated and State Partnership Exchanges. April 2013.