AFFORDABLE CARE ACT UPDATE
MAY 2016

HHS NOTICE OF BENEFIT AND PAYMENT PARAMETERS FOR 2017 AND 2017 LETTER TO ISSUERS IN THE FEDERALLY-FACILITATED MARKETPLACES

SUMMARY
At the end of February 2016 the U.S. Department of Health and Human Services (HHS) issued the Notice of Benefit and Payment Parameters for 2017 final rule to establish, among other provisions:

- “Standardized options” for metal-level plans in the individual market Federally-Facilitated Exchanges (FFEs) such as Illinois’;
- Policies relating to network adequacy for Qualified Health Plans (QHPs) on the FFEs;
- Program requirements for Navigators, certain non-Navigator assistance personnel, and certified application counselors to improve consumers’ ability to make choices regarding health insurance coverage;
- Provisions to enhance the transparency of rates in all states and the effectiveness of the rate review programs;
- Dates for the individual market annual open enrollment period for 2017 and future benefit years;
- Final proposals for the risk adjustment program and risk corridors provisions related to the reporting of allowable costs; and
- Final provisions related to enrollee cost sharing.

At the same time, the Centers for Medicare and Medicaid Services (CMS) issued the 2017 Letter to Issuers in the Federally-facilitated Marketplaces (FFM) to provide operational and technical guidance to issuers seeking to offer QHPs in 2017. The 2017 Letter closely mirrors the Payment Parameter rule, but provides more guidance specific to how issuers must comply with the rule.

OF PARTICULAR NOTE TO IHA MEMBERS:
- Overarching network adequacy requirements (but no specific provider/enrollee ratios or time/distance requirements) that members should be aware of as the state explores passing Illinois specific network adequacy standards (Section 156.230);
- Employer requirements members will have to be aware of for their hospital staffs (Section 155.310);
- QHP issuer patient safety standards that issuers will have to collect from in-network hospitals built around current Medicare and Medicaid patient-safety-standard requirements (Section 156.1110);
• Requirements relating to Navigators, Non-Navigator Assistance Personnel, and Certified Application Counselors if members participate in these enrollee assistance services (Sections 155.210, 155.215 and 155.225); and
• Provider Directory Links and Provider Lookup Tool requirements for QHP issuers (Chapter 3, Section 1 of the Letter).

**Benefit and Payment Parameters for 2017 - Major Provisions**

**Section 144.103 Definitions** - Allows states to retain the definition of small employers as employers with between 1 and 50 employees to be consistent with recent federal legislation. Originally the ACA would have required states to change the definition of small employer to employers with between 1 and 100 employees. IHA supported retaining the current definition to ensure markets were not unnecessarily destabilized.

**Section 154.215 Submission of rate filing justification** - HHS will post information for all proposed rate filings for the individual and small group markets within a state at a uniform time to promote fair market competition between issuers through and outside of the Exchange and further enhance transparency of the rate-setting process. States with an effective rate review program, including Illinois, are still required to post proposed rate increases subject to review and have a mechanism for receiving public comments on those proposed rate increases.

**Section 155.210 Navigator program standards** - Establishes that Navigators provide targeted assistance to underserved areas beginning with Navigator grants in 2018 and enlarging the subject matter about which Navigators can advise consumers on post-enrollment assistance to include:

• Eligibility appeals;
• Shared responsibility exemptions;
• Premium tax credit reconciliation;
• Rights related to health coverage; and
• Referrals to tax advisers.

As advocated by IHA and others, these requirements were not made mandatory for non-Navigator assistance personnel in order to ensure such personnel were not unnecessarily dissuaded from assisting consumers.

**Section 155.215 Standards applicable to Navigators and Non-Navigator Assistance Personnel** - Requires Navigators to disclose to consumers, prior to providing assistance, that Navigators are not acting as tax advisers or attorneys when providing assistance as Navigators and cannot provide tax or legal advice within their capacity as Navigators.

**Section 155.225 Certified application counselors** - Establishes quarterly data reporting by certified application counselors (CACs), rather than the proposed monthly reporting requirement contained in the original proposed rule. This is in response to commenters,
including IHA, who indicated that the addition of burdensome requirements on volunteer CACs could lead to a loss of such counselors. This reporting will begin in the third quarter of 2017. In addition, this Section requires CACs to disclose to consumers, prior to providing assistance, that CACs are not acting as tax advisers or attorneys when providing assistance as CACs and cannot provide tax or legal advice within their capacity as CACs.

Section 155.310 Eligibility process - Establishes that HHS must notify an employer that an employee has been determined eligible for advance payments of the premium tax credit and cost-sharing reductions only when the employee has also enrolled in a qualified health plan through the Exchange. Prior to this rule, notification was to occur anytime an employee qualified for premium tax credit and cost-sharing reductions whether enrolling in an Exchange QHP or not.

Section 155.335 Annual eligibility redetermination - Establishes the hierarchy for automatic renewing or reenrolling enrollees giving deference to reenrollment at the same metal level.

Section 155.410 Initial and annual open enrollment periods - Establishes that:

- For benefit years beginning on January 1, 2016, January 1, 2017, and January 1, 2018, the annual open enrollment period begins on November 1 of the calendar year preceding the benefit year, and extends through January 31 of the benefit year.
- For benefit years beginning on January 1, 2019 and beyond, the annual open enrollment period begins on November 1 and extends through December 15 of the calendar year preceding the benefit year.
- Selections must be made by the 15th of the preceding month for coverage to become effective on the 1st of the month. Thus, for coverage to be effective on January 1, selection must be made by December 15. This provision mirrors the existing federal requirement.

Section 155.705 Functions of a Small Employer Health Options Programs (SHOP) - For plan years beginning January 1, 2017, small employers will have three types of plan selection options from which employees could choose:

- A vertical option whereby employers would allow employees to select any metal option offered by a single issuer;
- A single plan offered by a single issuer; or
- A horizontal option in which employees could select from any plan at a specified metal level.

Currently, employers only have the option of offering the last two choices. For federally-facilitated SHOP exchanges, states could opt out of this option by submitting a request to HHS. The rule also provides for rules relating to the employer and employee contribution methodologies.

Section 156.230 Network Adequacy Standards - The rule:
• Requires, for purposes of continuity of care, that issuers make a good faith effort to provide covered persons with 30-day notice of a provider’s discontinuation with the network with or without cause, or non-renewal (similar to Illinois law);
• Establishes that issuers could negotiate with a provider who is terminated or non-renewed without cause for payment for services, but issuers would only be responsible for paying to a provider what was previously being paid under the same terms and conditions of the provider contract, including any protections against balance billing (similar to Illinois law). HHS indicates it cannot require non-contracted providers to accept a particular payment rate. Therefore, nothing would prohibit balance billing from a non-contracted provider if the provider refused to accept the issuer’s negotiated amount and the patient wanted to continue treatment with that provider. This means that an enrollee could be balance billed for the services and those balance billing amounts would not be required to count toward the plan’s annual limitation on cost sharing; and
• Requires, beginning for 2018 benefit year, issuers count cost sharing for essential health benefits provided by out-of-network, ancillary providers (that is, the provider of a service ancillary to what is being provided by the primary provider, such as anesthesiology or radiology) toward the annual limitations on cost sharing when the network is inadequate; or provide a written notice to the enrollee, by the longer of when the issuer would typically respond to a prior authorization request timely submitted, or 48 hours before the provision of the benefit, that additional costs may be incurred for an essential health benefits provided by an out-of-network ancillary provider in an in-network setting, including balance billing charges, unless such costs are prohibited under state law, and that any additional charges may not count toward the in-network annual limitation on cost sharing. Illinois law already addresses this “surprise billing” issue (see 215 ILCS 5/356z.3a/Public Act 98-154).
• Of important note, the rule does not establish minimum network adequacy standards relating to prospective time and distance standards or prospective minimum provider to covered person ratios for the specialties with the highest utilization rate in the states as was envisioned in the proposed rule. HHS commits to continue working with states in the implementation of the NAIC Network Adequacy Model Act and developing and promulgating network adequacy protections.

Section 156.1110 Establishment of patient safety standards for QHP issuers - Establishes that:
• For plan years prior to January 1, 2017, a QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Conditions of Participation requirements for a quality assessment and performance improvement program and discharge planning;
• For plan years beginning January 1, 2017 and after, a QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital utilizes a patient safety evaluation system, and implements a mechanism for comprehensive person-centered
hospital discharge to improve care coordination and health care quality for each patient or implements an evidence-based initiative, to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause-preventable harm, prevents hospital readmission, or improves care coordination;

- Issuers must collect documentation from such hospitals to demonstrate their compliance with the requirements; and
- A “patient safety evaluation system” means the collection, management, or analysis of information for reporting to or by a patient safety organization (PSO).

**Section 156.1250 Acceptance of certain third party payments** - Establishes that issuers offering individual market QHPs must accept premium and cost-sharing payments for the QHPs from:

- A Ryan White HIV/AIDS Program;
- An Indian tribe, tribal organization, or urban Indian organization; and
- A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.

HHS continues to consider whether to expand the list of entities from which issuers are required to accept payment to include not-for-profit charitable organizations.

**Section 156.1256 Other notices** - Establishes that a health insurance issuer that is offering QHP coverage must notify its enrollees of material plan or benefit display errors and the enrollees’ eligibility for a special enrollment period within 30 calendar days after being notified by the FFE that the error has been fixed. Errors to provider networks or drug formularies, whether incorrectly displayed on the issuer’s website or accessible through the premium estimator tool on HealthCare.gov, generally do not qualify an enrollee for a special enrollment period.

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**2017 LETTER TO ISSUERS – MAJOR PROVISIONS**

**CHAPTER 1: CERTIFICATION PROCESS FOR QUALIFIED HEALTH PLANS**

**Section 1. QHP Application and Certification Process**

As was the case for prior benefit years, CMS expects to rely on states’ reviews of policy forms and rate filings submitted by issuers for market-wide standards as part of its QHP certification process, provided that states review for compliance with federal laws and regulations and complete the reviews in a manner consistent with FFM operational timelines.

The Letter establishes the following timelines (all dates subject to change):

- Deadline for Submission of Revised QHP Data 6/30/2016
- CMS Reviews Revised QHP Data as of 6/30/16 7/01/2016 – 8/02/2016
Deadline for Issuer Submission of Changes to QHP Applications; Deadline for All Risk Pools with QHPs to be in “Final” Status in the Unified Rate Review (URR) System 8/23/2016

- CMS Reviews Final QHP Data Received as of 8/23/16 8/24/2016 – 9/09/2016
- States Send CMS Final Plan Recommendations 9/08/2016
- CMS Sends Certification Notices to Issuers 9/15/2016 – 9/16/2016
- Issuers Send Agreements and Plan List to CMS 9/19/2016 – 9/23/2016
- CMS Sends Validation Notice to Issuers 10/03/2016 – 10/04/2016
- Open Enrollment 11/01/2016 – 1/31/2017

Section 4. Standardized Options

The 2017 Payment Notice Final Rule finalized standardized options at each of the bronze, silver (including the three silver cost-sharing reduction plan variation levels), and gold metal levels—a total of 6 standardized options (see Table 9 in the 2017 Payment Notice Final Rule), which issuers will have the option to offer starting in the 2017 plan year.

CHAPTER 2: QUALIFIED HEALTH PLAN AND STAND-ALONE DENTAL PLAN CERTIFICATION STANDARDS

Section 1. Licensure and Good Standing

Describes issuer requirements for licensure and good standing and how CMS will review prospective QHPs and Stand Alone Dental Plans (SADPs) for compliance with these standards in the FFMs, including that each QHP issuer must be licensed and in good standing in each state in which it applies to offer QHPs for the applicable market, product type, and service area.

Section 2. Service Area

The Marketplace must ensure that each service area of a QHP covers a minimum geographic area that is at least the entire geographic area of a county, or a group of counties defined by the Marketplace, unless the Marketplace determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers.

The Marketplace must also ensure that the service area of a QHP has been established without regard to racial, ethnic, language, or health status-related factors or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

Section 3. Network Adequacy

- The 2017 Payment Notice Final Rule did not finalize policies concerning network adequacy time and distance standards as proposed. Therefore, CMS is not finalizing all of the policies proposed in the Draft 2017 Letter to Issuers in the FFMs. CMS is continuing to use the reasonable access standard so that states have time to adopt the NAIC Network Adequacy Model Act provisions. However, while CMS is not finalizing network adequacy time and distance standards, they do provide clarity on the criteria previously used and which will be used as part of the certification process to review
network provider data to determine if plans provide reasonable access to covered services.

- In addition, CMS intends to label each QHP network’s breadth as compared to other QHP networks on HealthCare.gov. This information will be available to consumers when they are considering which plan to enroll in, and would include a designation that indicates the network’s relative breadth. The purpose of the labeling is to provide increased transparency to enrollees about the type of provider network in the coverage they are selecting.

**Section 4. Essential Community Providers (ECPs)**

Because the number and types of ECPs available vary significantly by location, and consistent with the approach in prior years, CMS intends to evaluate QHP applications for sufficient inclusion of ECPs for plan years beginning in 2017 against the ECP inclusion standard established in the Letter. While establishing an alternate ECP standard, CMS will use a general ECP enforcement standard whereby it will consider the issuer to have satisfied the regulatory standard if an application demonstrates satisfaction of the following criteria:

- Contracts with at least 30 percent of available ECPs in each plan’s service area to participate in the plan’s provider network;
- Offers contracts in good faith to all available Indian health care providers in the service area, to include the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations, applying the special terms and conditions necessitated by federal law and regulations as referenced in the recommended model QHP Addendum for Indian health care providers developed by CMS; and
- Offers contracts in good faith to at least one ECP in each ECP category in each county in the service area, where an ECP in that category is available and provides medical or dental services that are covered by the issuer plan type.

**Section 7. Quality Reporting**

CMS will review QHP issuer compliance with the quality reporting standards related to the Quality Rating System (QRS) and the QHP Enrollee Experience Survey (QHP Enrollee Survey) for purposes of QHP certification. QHP issuers offering coverage through the Marketplaces must collect and submit validated clinical quality measure data and QHP Enrollee Survey response data, on a timeline and in a standardized form and manner specified by CMS, to support the calculation of QRS ratings. QHP issuers are also required to contract with and authorize an HHS-approved QHP Enrollee Survey vendor to collect and submit QHP Enrollee Survey response data on their behalf. Beginning in the 2016 calendar year, and on an annual basis thereafter, all Marketplaces must prominently display QHP quality rating information on their respective websites, as calculated by CMS and in a form and manner specified by CMS.

**Section 8. Quality Improvement Strategy (QIS) Requirements**

All issuers offering QHPs through the Marketplaces that meet participation criteria must comply with the QIS requirements as a condition of certification and participation in the Marketplaces.
CMS will review QHP issuer compliance with the quality reporting standards related to the QIS for purposes of QHP certification.

CHAPTER 3: DECISION SUPPORT TOOLS

Section 1. Provider Directory Links and Provider Lookup Tool

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 FFMs, CMS, and the United States Office of Personnel Management (OPM).

CMS will consider a provider directory to be up-to-date if the issuer updates it at least monthly. Additionally, CMS will consider a provider directory to be easily accessible when the general public is able to view all of the current providers for a plan in the provider directory on the issuer’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 plans and provider networks. Further, if the health plan issuer maintains multiple provider networks, the plans and provider network(s) associated with each provider, including the tier in which the provider is included, should be clearly identified on the website and in the provider directory.

CHAPTER 5: QUALIFIED HEALTH PLAN PERFORMANCE AND OVERSIGHT

Section 4. FFM Oversight of Agents and Brokers

The FFMs do not set compensation levels or pay commissions to agents or brokers. The FFMs do not play a role in setting compensation levels or making appointments between issuers and agents and brokers, and the FFMs are not a party to the contract between the QHP issuer and the agent or broker. However, federal regulations require QHP issuers to provide the same compensation to agents and brokers for QHPs offered through the FFMs as they do for similar health plans offered in the state outside the Marketplaces. A compensation arrangement in which an issuer pays no commission for sale of a QHP through an FFM, but does pay commission for sale of a similar plan outside of the FFM, would violate this FFM standard for agent and broker compensation.

Recent actions by insurers to eliminate commissions for agents and brokers in the individual marketplace have raised concerns among some stakeholders including IHA. Elimination of commissions could, intentionally or not, allow issuers to avoid covering populations that are required to be offered QHPs and thus present an argument that such actions avoid federal guarantee issue requirements for policies and may be discriminatory.

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