American Hospital Association

Special Bulletin

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CMS Issues Final rule on 2017 Notice of Benefit and Payment Parameters

The Centers for Medicare & Medicaid Services (CMS) Feb. 29 issued its final rule implementing standards that govern health insurance issuers and the Health Insurance Marketplaces for 2017. The final rule includes the benefit and payment parameters for qualified health plan (QHP) issuers selling in the marketplaces and makes a number of policy changes that impact hospitals and health systems, including those that offer health plans. **The AHA is pleased that CMS took several steps in this rule to protect consumers and facilitate meaningful choice; however, we do not believe that its finalized policies go far enough, particularly with respect to implementing national network adequacy standards and protecting consumers from "surprise bills."**

Among other policy updates in the rule, CMS:

- Did not adopt a national minimum network adequacy standard and instead encouraged states to continue to develop standards by implementing the National Association of Insurance Commissioners' (NAIC's) Health Benefit Plan Network Access and Adequacy Model Act (NAIC Network Adequacy Model Act);
- Expanded current regulations related to patient safety standards for hospitals;
- Changed the cost-sharing limit rules beginning in 2018 as they relate to bills for out-of-network providers delivering services at in-network facilities;
- Created a new type of marketplace model for states wishing to leverage some functions of the federal infrastructure;
- Established standardized plan options to facilitate consumer choice;
- Implemented new requirements to facilitate continuity of care when a provider leaves a plan's network;
- Confirmed its intentions to develop and publicly post ratings of each QHP's network coverage;
- Recalibrated the risk-adjustment formula using more recent and complete data; and
- Set the annual open enrollment period for 2017 as Nov. 1, 2016 to Jan. 31, 2017.

Hospitals and health systems may be most impacted by the final policies related to network adequacy and revisions to the patient safety standards for hospitals contracting

with QHPs. In addition, providers with health plans will want to carefully review the broader array of policy changes, such as those related to the premium stabilization programs, the new standardized plan options, and limits on cost sharing, among others.

Highlights of the final rule, including these and other policy changes, follow.

HIGHLIGHTS

Network Adequacy Standards. In the final rule, CMS moved forward with several of its proposed changes to its network adequacy standards. Specifically, CMS implemented changes to facilitate continuity of care when a provider leaves a plan's network and to protect enrollees from "surprise bills." CMS also indicated its intent to develop ratings of each QHP's network coverage. CMS, however, declined to adopt a minimum quantitative network adequacy threshold for each state, but instead stated its expectation that states continue to work to implement standards based on the NAIC Network Adequacy Model Act. CMS will monitor states' progress in adoption of network adequacy standards and may revisit minimum quantitative standards in the future. In the meantime, CMS will continue to use the current network adequacy standards in reviewing plans for QHP certification. More information on those standards is included in the annual Letter to Issuers, which was issued concurrently with this final rule. **While the AHA had supported the adoption of a minimum quantitative network adequacy threshold for each state, we also strongly support the NAIC Model Act as a comprehensive framework for states to follow.**

In an attempt to minimize "surprise bills" from out-of-network providers providing care in in-network facilities, CMS will require plans to count enrollee cost sharing for an essential health benefit (EHB) provided by an out-of-network provider toward the enrollee's annual limitation on cost sharing beginning in 2018. Alternatively, health plans will have to provide enrollees with a written notice in advance of receiving the service that provides sufficient information on the implications for choosing to receive care from an out-of-network provider for the enrollee to make an informed choice. **While a step in the right direction, this final policy falls short of AHA's recommendation that CMS look to the NAIC Model Act, which offers greater consumer protections by requiring that insurers establish payment programs for out-of-network providers and, should providers fail to accept the terms, require that the insurer and the provider enter into a structured mediation process to address the claim without involving the enrollee.**

With respect to continuity of care, CMS is requiring issuers to provide advance written notice 30 days in advance to all enrollees who are seen on a regular basis or receive primary care from a provider who will no longer be a part of the plan's network. When an enrollee is in active treatment with such a provider, the issuer must allow the enrollee to either complete the treatment or continue it for 90 days, whichever is shorter, at in-network cost-sharing rates.

Finally, CMS announced its intent to include a rating of each QHP's network coverage on HealthCare.gov to increase transparency and the availability of meaningful information to facilitate consumer choice. CMS expects to develop the rating measure by comparing the breadth of the QHP network at the plan level with other plans available in the same geographic area.

Patient Safety Standards for QHP Issuers. For plan years beginning on or after Jan. 1, 2017, CMS expanded current regulations related to patient safety standards for hospitals. **As the AHA urged, the agency adopted important flexibilities in how these requirements are met.** The final rule requires QHP issuers to verify that their contracted hospitals of more than 50 beds either:

- Utilize a patient safety evaluation system as defined in 42 CFR 3.20 (regulations related to federally-listed patient safety organizations (PSOs)) and implement a mechanism for comprehensive person-centered hospital discharge; or
- Implement 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.

For those hospitals that choose the second option, CMS does not provide a list of initiatives that would qualify. Instead, the agency says the requirements are intended to be broad and inclusive of various initiatives to allow for flexibility and innovation. CMS explicitly states that some local, state or national patient safety reporting programs may qualify.

The documentation requirements also are flexible, and CMS includes examples such as hospital attestations or current agreements to partner with a PSO, Hospital Engagement Network or Quality Improvement Organization. CMS states, "We believe it is important to allow for flexibility regarding methods of complying with the new documentation requirements . . . in order to balance both issuer and hospital burden and to accommodate a variety of types of patient safety initiatives in which hospitals may engage." Hospitals that choose to partner with a PSO may continue sharing their CMS certification numbers with QHP issuers in order to meet the requirement to demonstrate implementation of a mechanism for comprehensive, person-centered discharge.

Premium Stabilization – The 3 R's. CMS finalized a variety of updates and technical changes to the reinsurance, risk corridor and risk-adjustment programs designed to mitigate risk for issuers in the individual marketplaces. The risk adjustment program is a permanent element of the Affordable Care Act (ACA) market reforms, while the reinsurance and risk corridor programs are three-year programs that conclude at the end of 2016. With regard to reinsurance, CMS finalized the proposal to expend all remaining reinsurance funds as payments for the 2016 benefit year, which may require

that the agency increase the co-insurance rate and reduce the attachment point. With regard to risk corridors, CMS is requiring insurers to "true up" claims liabilities and reserves used to determine the allowable costs reported for the preceding benefit year to reflect the actual claims payments made through March 31 of the year following the benefit year for 2015 and 2016. CMS made this change to calculate risk corridors more accurately by using actual data in place of estimates. With regard to risk adjustment, CMS will update the risk factors with more current data and incorporate preventive services and prescription drug information.

Creation of the "State-based Exchange using the Federal Platform" Model. CMS has established a new exchange model for state-based exchanges that want to use the federal eligibility enrollment infrastructure for certain functions. Many of the rules that apply in the federally facilitated marketplace model will apply to this model as well, such as QHP requirements and rules regarding agents and brokers. CMS will charge states a fee to offset the cost of providing this infrastructure.

Standardized Plan Options. CMS established standard cost sharing structures at each of the bronze, silver and gold levels and will encourage insurers to offer plans that adopt the standardized structure. CMS hopes that these plans will ease consumer choice by facilitating comparisons. CMS is not requiring issuers to offer standardized options, nor limiting insurers' ability to offer other QHPs.

Special Enrollment Periods (SEPs). CMS codified several changes to the SEPs and indicated that it will conduct an assessment of whether further changes are needed. Specifically, CMS will require that individuals seeking to use certain common SEPs will need to provide documentary evidence of their eligibility. CMS also has discontinued the use of several SEPs that it determined are no longer needed.

Premium Payment Grace Period and Third-party Payment of Premiums. The rule finalizes amendments to the regulations regarding the three-month grace period for individuals receiving premium tax credits who fail to pay their premiums. Specifically, it clarifies that, if an individual loses his or her premium tax credit during the three-month grace period of non-payment of the premium, the three-month grace period still applies and the individual can continue to access health services. In this case, health plans are only obligated to pay for care during the first month of the three-month period, which puts providers at risk for nonpayment of claims for services delivered during the second and third months.

With regard to current rules governing third-party payments for QHP premiums, the final rule restates that insurers must accept premium payment from local government grantees that are funded by state and local governments, including Ryan White HIV/AIDS program; federal and state government programs that provide premium and cost-sharing support for specific individuals; and Indian tribes, tribal organizations and urban Indian organizations. CMS did not make any changes with respect to non-profit

charitable organizations. **The AHA is disappointed in CMS's failure to require that QHPs accept third-party premium and cost-sharing payments from hospitals, hospital-affiliated foundations and other charitable organizations.** We believe this decision undermines one of the core objectives of the ACA – making affordable insurance coverage available to the uninsured – and adversely impacts those who need it most, the poor and the sick.

Essential Community Providers (ECP). CMS finalized its proposal to continue in 2017 to consider multiple providers at a single location as a single ECP for purposes of determining both a plan's count of ECPs and the available number of ECPs in the plan's service area. However, for certification cycles beginning with the 2018 benefit year, CMS will credit insurers for multiple contracted full-time equivalent (FTE) practitioners at a single location, up to the number of available FTE practitioners reported to CMS by the ECP facility through the ECP petition process. CMS also finalized its approach to not disaggregate certain ECP categories. **The AHA is concerned that such an approach puts certain subpopulations at risk.** For example, CMS will not uniquely evaluate access to children's hospitals as separate from general acute care hospitals and, therefore, puts children's access to appropriate services at risk.

Re-enrollment Hierarchy. CMS finalized with some modifications its proposed revisions to the automatic re-enrollment process. Under the modified approach, individuals in a silver-level QHP that are no longer available for re-enrollment will be enrolled in another silver-level QHP that is the most similar to the enrollee's current product (i.e., same product network type with the lowest premium). CMS updated the proposal to require that automatic re-enrollment occur through the exchange, as opposed to outside the exchange. While this change could result in more individuals being moved to a plan offered by a different issuer, it ensures enrollees maintain access to cost-sharing reductions in silver plans.

Navigators and Assisters. CMS finalized new requirements for navigators, non-navigator assistance personnel and consumer assisters. Specifically, navigators in all marketplaces will be required to provide targeted assistance to underserved and vulnerable populations as defined by the marketplace. Navigators also will be required to provide post-enrollment assistance including on eligibility appeals, reconciliation with premium tax credit assistance and assisting in health care insurance literacy, beginning with navigator grants awarded in 2018. State-based Marketplaces have the option of implementing the same requirements. CMS also finalized a requirement that navigators and non-navigator assistance personnel are required to complete training prior to performing outreach and education activities as well as prior to providing application or enrollment assistance. Finally, CMS requires certified application counselor designated organizations to provide performance data to the marketplaces they serve upon request.

Medical Loss Ratio (MLR). For purposes of calculating medical loss ratios, CMS retains the existing policy of using a three-month period for reporting incurred claims used in the MLR calculation. CMS opted not to allow insurers to claim investments in fraud prevention activities as incurred claims for purposes of the MLR.

Premium Rate Disclosure. In order to increase transparency in the rate setting process, CMS will require all insurers to submit the unified rate review template (URRT) for all single risk pool products in the individual and small group markets regardless of whether the insurer proposes to increased, decrease or maintain the current product rate. This information will be publically posted.

Hardship Exemption. CMS finalized its proposal to simplify the process for seeking an exemption from the ACA's individual responsibility requirement for those individuals living in states that have not expanded their Medicaid programs. Specifically, individuals seeking a hardship exemption will no longer have to undergo an eligibility determination for Medicaid. The Marketplace instead will be able to determine that the individual "would have been eligible for Medicaid," allowing the individual to claim an exemption on his/her federal tax return instead of seeking an exemption certificate from the Marketplace.

Essential Health Benefits (EHBs) and Opioid Addition. In the proposed rule, CMS sought comment on whether the substance use disorder requirement under EHB needed additional clarification with regard to medication assisted treatment (MAT) for opioid addiction. In the final rule, CMS indicated that it anticipates issuing separate guidance with respect to MAT in the near future.

NEXT STEPS

For more information on the patient safety standards for QHP issuers, contact Evelyn Knolle, AHA senior associate director for policy development, at eknolle@aha.org. For all other provisions, contact Molly Smith, AHA senior associate director for policy development, at mollysmith@aha.org.