

Georgians for a Healthy Future (GHF) submitted [comments](file:///C:\Users\Amber\AppData\Local\Temp\Temp1_Re%253a_2017_NBPP.zip\Comment%20Letter\GHF%20Comment%20Letter%202017%20BPP%20proposed%20rule_clean.pdf) to the Centers for Medicare and Medicaid Services (CMS) on the proposed 2017 Benefit and Payment Parameters [rule](file:///C:\Users\Amber\AppData\Local\Temp\Temp1_Re%253a_2017_NBPP.zip\Rule\2017%20BPP%20Proposed%20Rule.pdf) in December 2015. CMS issued the [final rule](file:///C:\Users\Amber\AppData\Local\Temp\Temp1_Re%253a_2017_NBPP.zip\Rule\2017%20BPP%20Final%20Rule.pdf) in March 2016. Below are highlights from the proposed and final rules, and GHF’s position on provisions for 2017.

**Part 154 – Health Insurance Issuer Rate Increases: Disclosure and Review Requirements**

**§154.215 Submission of Rate Filing Justification**

**Proposed Rule:** Require that issuers submit a Rate Filing Justification for all single risk pool coverage products in the individual, small group or merged markets not only when they are planning to increase or decrease a rate, or not modify at all.

**Final Rule:** The provisions in the proposed rule were adopted.

**GHF Position:** We support CMS’s decision to expand what information is disclosed to include all proposed rates because it gives consumers a more complete understanding of the changes in insurance rates.

**§154.301 CMS’s Determinations of Effective Rate Review Programs**

**Proposed Rule:** Make all proposed rate filing information publicly available, if it is not trade secret or confidential commercial or financial information. For states to be considered to have effective rate review programs they must also make information available to the public on proposed rate increases subject to review and final rate increases, and they must do so at a uniform time*.*

**Final Rule:** The provisions in the proposed rule were adopted. CMS released a bulletin on timing of rate filing submissions. Final rates will be effective no later than the first day of open enrollment, November 1, 2016.

**GHF Position:** We commend CMS for taking steps to ensure consumers have access to all proposed rate filings and making information on final rate increases publicly available prior to the first day of the annual open enrollment period. For future rule making, we recommend adding the following to an effective rate review program: a sixty-day comment period on all proposed rate increases and requirement for state’s website to prominently display all filing documents.

**Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges**

**§ 156.230 Network Adequacy Standards**

**State Selection of Minimum Network Adequacy Standards**

**Proposed Rule:** Federally Facilitated Exchange (FFE) states are required to set quantifiable network adequacy metrics for time and distance standards and prospective minimum provider-enrollee ratios for the specialties with the highest utilization rate for its state. FFE states that do not set standards will be subject to a federal default. CMS also proposed to clarify process for determining network adequacy for qualified health plans (QHP) that use a tiered network.



**Final Rule:** HHS decided to give states time to act on NAIC recommendations before requiring minimum network adequacy standards. HHS will monitor the practice of tiering, but will not necessarily focus only on access to providers included in the lowest tier of coverage. Starting in 2017, HealthCare.gov will include a rating of each QHP’s relative network size. The measure will compare the QHP network size at the plan level to the network size of plans available in the same geographic area.

**GHF Position:** While we are encouraged by some of the network adequacy provisions in the final rule, we are not in agreement with the pull-back on setting minimum network adequacy standards and clarifying the process for determining network adequacy for QHPs that use a tiered network.

**Additional Network Adequacy Requirements**

***Continuity of Care***

**Proposed Rule:** Require QHP issuers in all FFEs to notify enrollees about a discontinuation of an in-network provider as well as ensuring that enrollees have continuity of care protections when a provider is terminated without cause. Also, allow enrollees in active treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates in cases where their provider is terminated.

**Final Rule:** CMS will require insurers to notify enrollees 30 days when terminating a provider and continue to offer coverage for up to 90 days for a patient in active treatment by that provider. The insurer would only have to pay network rates for the services of that provider and the provider could balance bill.

**GHF Position:** In general, we support these important consumer protections, but believe they are important enough to warrant applying them to all QHPs, not just those in FFE states. Further, we believe that the 90-day transition period should be the minimum, rather than the maximum, length of time for patients being treated for a life-threatening condition, a serious acute condition, in the second or third trimester, through the postpartum period, or in a course of treatment where discontinuing treatment would worsen the condition. Lastly, continuity of care should not be subject to balance billing.

***Cost Sharing Protections***

**Proposed Rule:** A plan may provide notice to an enrollee at least 10 days in advance that enrollees may receive care from out-of-network provider services at in-network facilities. If a plan fails to provide this notice, any cost-sharing imposed by out-of-network providers at an in-network facility must be charged against the plan’s OOP limit so that the insurer absorbs costs above that limit. The provision would apply to all QHP plans, not just FEE.



**Final Rule:** The final provisions contained a number of modifications, including shortening the notice period from 10 days to 48 hours; applying only to cost sharing paid by an enrollee for an EHB provided by an out-of-network ancillary provider in an in-network setting; implementing these requirements for the 2018 benefit year. CMS also clarified that the proposed rule did not prohibit true balance billing by out-of-network providers – and it does not apply to plans that do not cover out of network services

**GHF Position:** We appreciate CMS’s effort to put in place a provision to limit surprise bills to enrollees but we believe that this is an inadequate protection. Issuers can avoid responsibility by providing written notification to enrollees in advance about potential out-of-network costs. We strongly believe that enrollees should be protected from and should not be subject to out-of-network cost sharing in cases where they could not be reasonably expected to know or control whether care is being delivered by out of network providers.

**§ 156.235 Essential Community Providers**

**Proposed Rule:** Each full-time equivalent (FTE) practitioner at an essential community provider (ECP) location will be counted towards satisfying the QHP ECP requirement (and towards the ECPs in the area). Maintenance of the 30% ECPs in service area threshold.

**Final Rule:** For 2017 HHS will maintain its current policy of counting multiple providers at a single location as a single ECP provider. Beginning in 2018, HHS will allow health plans to count multiple FTE practicing at a single location as separate ECPs for meeting ECP participation requirement.

**GHF Position:** While we agree with the maintenance of current policy for 2017, we believe that the proposed change in 2018 would hamper access to care for low-income, underserved populations. The policy change would also be impossible to implement in a simple and accurate manner (See GHF comment letter for more detail). Also, ECP standards should be set to ensure that ECPs included in-network are appropriately distributed across the geography of a plan’s service area with a special emphasis on including an adequate number of ECPs, by type of specialty, in the lowest-income and most medically underserved areas of the service area.