Draft 2017 Letter to Issuers in the Federally-Facilitated Marketplaces

Summary of Key Changes Related to QHP Certification

January 12, 2016

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Agenda

I. Key Dates for QHP Certification

II. Network Adequacy and ECPs

III. Meaningful Difference

IV. Discriminatory Benefit Design and Prescription Drugs

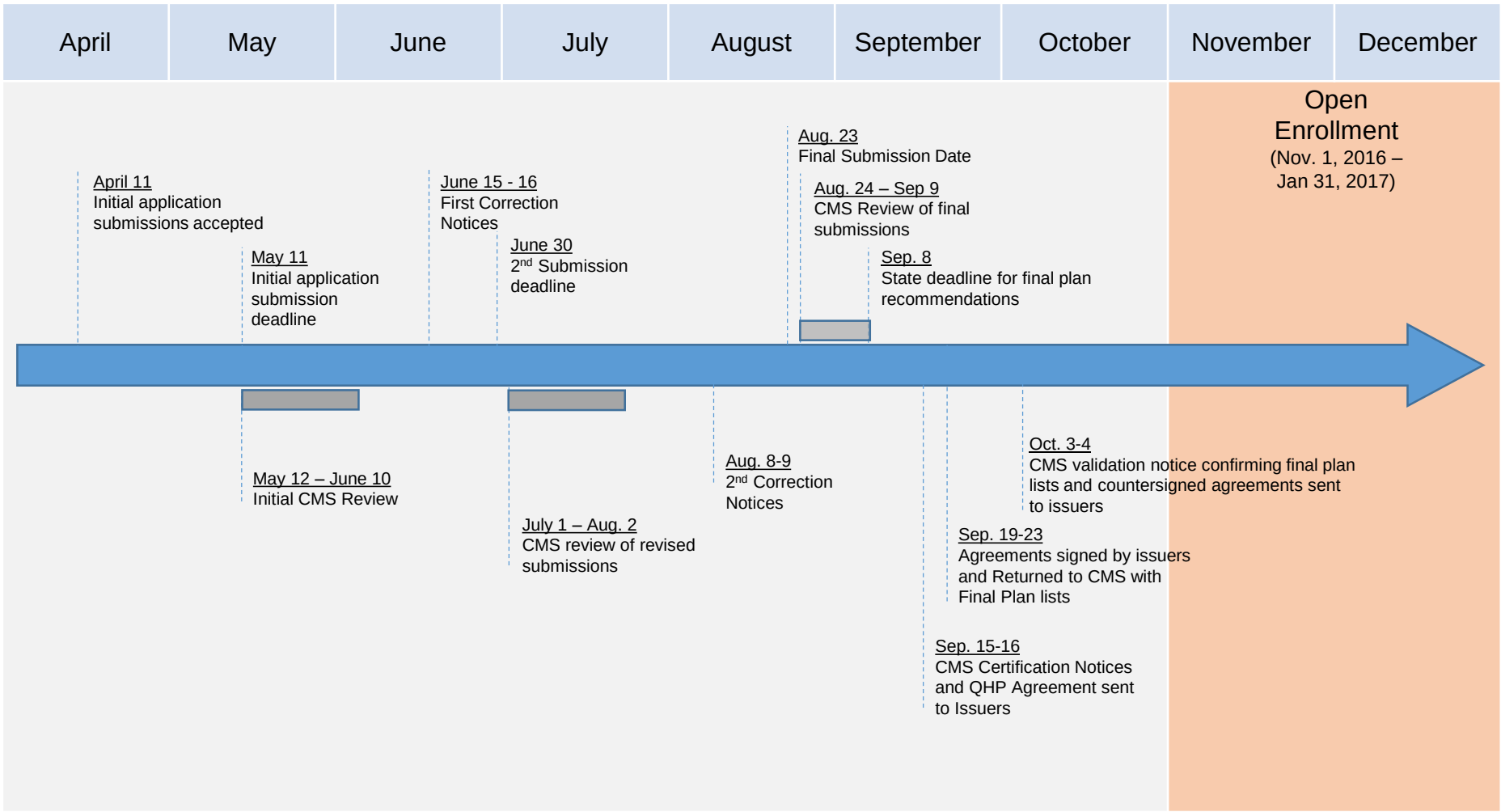
V. Quality Reporting Standards and Review

VI. Quality Improvement Strategy Requirements

VII. Summary of Benefits and Coverage

VIII. Q&A

Plan Year 2017 CMS QHP Certification Timeline



Network Adequacy and ECPs

Proposed Network Adequacy Changes

- CMS will rely on state reviews that use acceptable quantifiable metrics:
  - time and distance standards
  - minimum provider-to-covered person ratios
- CMS will work with states to confirm use of an acceptable metric
- Healthcare.gov will include a designation that indicates networks' relative breadth
  - Measured by percentage of available hospitals and PCPs in a county

Proposed ECP Changes

- New definition of "offer in good faith"
- For 30% ECP standard:
  - CMS will institute an ECP petition process
  - Write-in ECPs must submit a petition by 8/22
  - For SADPs, rejected good faith offers will be counted

Proposed Default FFM Standards

Specialty Area*	Maximum Time and Distance Standards (Minutes/Miles)				
	Large	Metro	Micro	Rural	CEAC
Primary Care	10/5	15/10	30/20	40/30	70/60
Dental	30/15	45/30	80/60	90/75	125/110
Endocrinology	30/15	60/40	100/75	110/90	145/130
Gynecology (OB/GYN)	30/15	45/30	80/60	90/75	125/110
Infectious Diseases	30/15	60/40	100/75	110/90	145/130
Oncology - Medical/Surgical	20/10	45/30	60/45	75/60	110/100
Oncology - Radiation/Radiology	30/15	60/40	100/75	110/90	145/130
Mental Health	20/10	45/30	60/45	75/60	110/100
Pediatrics	30/15	45/30	80/60	90/75	125/110
Cardiology	20/10	30/20	50/35	75/60	95/85
Rheumatology	30/15	60/40	100/75	110/90	145/130
Hospitals	20/10	45/30	80/60	75/60	110/100
Outpatient Dialysis	30/15	45/30	80/60	90/75	125/110
Inpatient Psychiatric Facility Services	30/15	70/45	100/75	90/75	155/140

***Must provide access to at least one provider for at least 90% of enrollees**

Meaningful Difference

Process

- CMS will organize issuer's QHPs into subgroups based on plan type, metal level, child-only plan status and overlapping counties / service areas
- CMS review each subgroup for at least one material difference in cost sharing, provider network, or covered benefits.

- **Cost Sharing:**
  - Integrated medical and drug maximum out-of-pocket (MOOP)
  - Integrated medical and drug deductible
  - $200 difference in MOOP
  - $100 difference in deductible
  - Multiple in-network tiers
- **Provider Networks:**
  - Different provider network IDs
- **Covered Benefits:**
  - Vary in coverage of one or more benefit displayed on healthcare.gov

Discriminatory Benefit Design and Prescription Drugs

- Outliers will be based on estimated out-of-pocket costs associated with the standard treatment protocols for medical services and drug regimens needed to treat:
  - bipolar disorder,
  - diabetes,
  - HIV,
  - rheumatoid arthritis,
  - schizophrenia.
- CMS will review the availability of drugs and related cost-sharing for: bipolar disorder, breast and prostate cancer, diabetes, hepatitis C, HIV, multiple sclerosis, prostate cancer, rheumatoid arthritis and schizophrenia
- CMS will also consider the impact of prescription drug tiering

Average cost for diabetes drug regimen

Flagged outlier cost for diabetes drug regimen

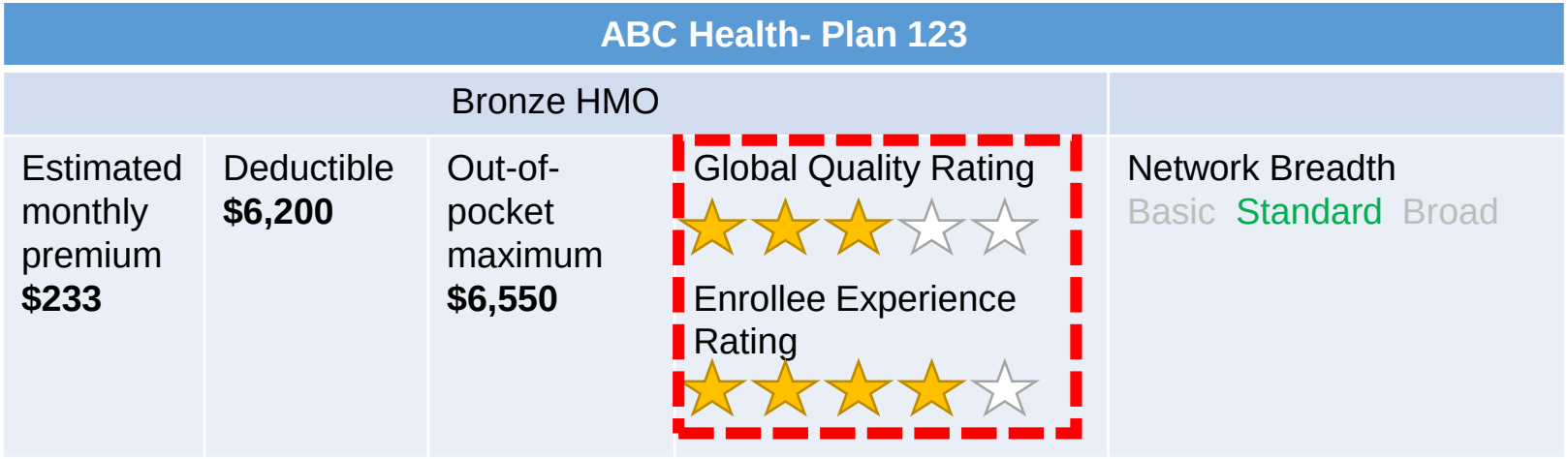
Quality Reporting Standards and Review

Quality Requirements

- QHP issuers are required to comply with **QRS** and **QHP Enrollee Survey** requirements**;** CMS released guidance for PY 2016 in September, and guidance for 2017 is forthcoming
- QHP issuers will be required to attest that they comply with these requirements as part of certification process for the PY 2017

Quality Rating Display

- For the first time, CMS will publicly display QHP quality star rating information (1-5 stars) on HealthCare.gov to help consumers compare QHPs
  - CMS also intends to separately release QHP quality rating information via public use data files
- QHP issuers may include 2016 QRS and QHP Enrollee Survey results in marketing materials for PY 2017



Quality Improvement Strategy Requirements

QIS Definition

- Payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees. QIS must also include activities related to:
  1. Improving health outcomes;
  2. Preventing hospital readmissions;
  3. Improving patient safety and reducing medical errors;
  4. Promoting wellness and health; and/or
  5. Reducing health and health care disparities.

Who has to participate?

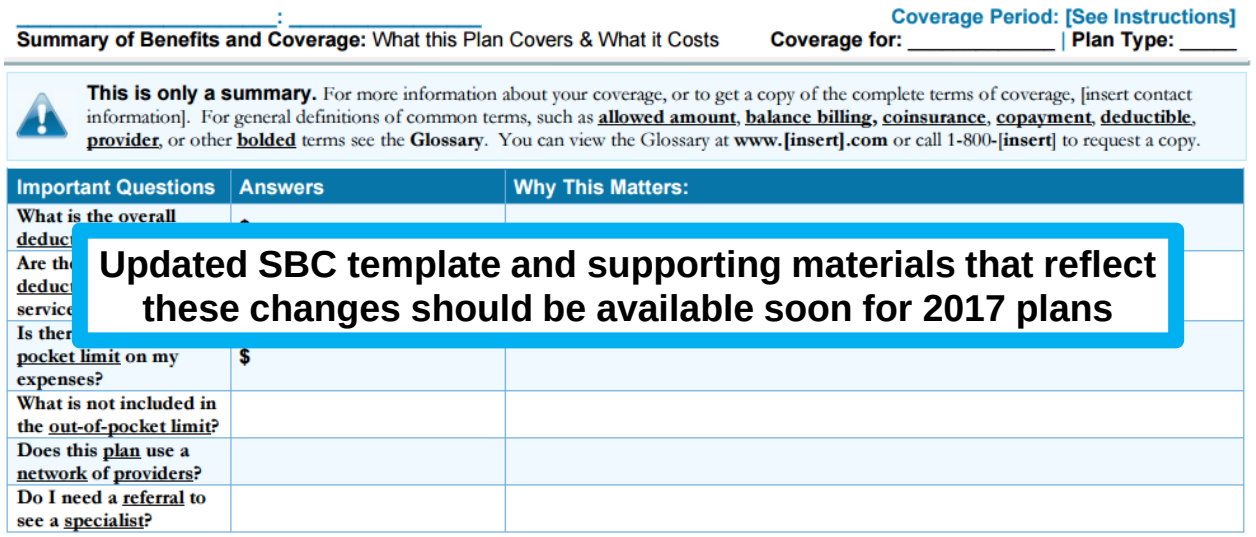
- Issuers covering 500 enrollees that offered marketplace coverage during 2014 and 2015 must implement one or more QIS that covers all of their QHPs; a QIS does not have to address the needs of all enrollees
- Issuers must: submit the QIS Implementation Plan during the 2017 certification process; implement the QIS beginning 1/2017; and submit a Progress Report the following year.
- QIS Guidelines were published 11/2015.

CMS will evaluate in FFM states; plan management states and FFM will do joint reviews; SBMs will review; OPM will review for multi-state plans.

Summary of Benefits and Coverage

SBC provisions were finalized on 6/2015

- SBCs must include a web address that links directly to a copy of the individual coverage policy or group certificate of coverage.
  - All URL links included on the SBC must link directly to the referenced information, such as the specific formulary for that SBC benefit package.
- SBCs must disclose whether or not the QHP pays for abortions for which federal funding is not available.
- QHP insurers are required to make SBCs available that accurately reflect each cost-sharing plan variation, and must include a separate URL linking to the SBC created for each plan variation as part of the QHP data submission.



_____: _____
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: [See Instructions]
Coverage for: _____ | **Plan Type:** _____

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other **bolded** terms see the **Glossary**. You can view the Glossary at **www.[insert].com** or call 1-800-**[insert]** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deduct		
Are th deduct service		
Is ther pocket limit on my expenses?	$	
What is not included in the out-of-pocket limit?		
Does this plan use a network of providers?		
Do I need a referral to see a specialist?		

Updated SBC template and supporting materials that reflect these changes should be available soon for 2017 plans

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