CMS issues the final HHS Notice of Benefit and Payment Parameters for 2016

Stronger standards for issuers and Marketplaces

The Centers for Medicare & Medicaid Services (CMS) has issued the Final HHS Notice of Benefit and Payment Parameters for 2016. This rule seeks to improve consumers[1] experience in the Health Insurance Marketplace and to ensure their coverage options are affordable and accessible. This rule builds on previously issued standards which seek to make high-quality health insurance available to all Americans. The final notice further strengthens transparency, accountability, and the availability of information for consumers about their health plans.

[3]We work every day to strengthen programs that deliver quality, affordable care to families across the country,[2] said CMS Administrator Marilyn Tavenner. [3]CMS is working to improve the consumer experience and promote accountability, uniformity, and transparency in private health insurance.[2]

The rule finalizes the annual open enrollment period for 2016 to begin on November 1, 2015 and run through January 31, 2016, giving consumers three full months to shop.

To further aid consumers in finding a health plan that best suits their needs, the rule clarifies standards for qualified health plan (QHP) issuers to publish up-to-date, accurate, and complete provider directories and formularies. Issuers also must make this information available in standard, machine-readable formats.

To enhance the transparency of the rate-setting process, the final rule includes provisions to facilitate public access to information about rate increases in the individual and small group markets for both QHPs and non-QHPs using a uniform timeline. It also includes provisions to further protect consumers against unreasonable rate increases by ensuring more rates are subject to review.

To ensure consumers have access to high-quality, affordable health insurance, premium stabilization programs were put in place to promote price stability for health insurance in the individual and small group markets. This rule includes additional provisions and modifications related to the implementation of these programs, as well as the key payment parameters for the 2016 benefit year.

Additionally, the rule will help consumers access the medications they need by improving the process by which an enrollee can request access to medications not included on a plan[1]s formulary. The rule provides more detailed procedures for the standard exception process, and adds a requirement for an external review of an exception request if the health plan denies the initial request. It also clarifies that cost-sharing for drugs obtained through the exceptions process must count toward the annual limitation on cost sharing of a plan subject to the essential health benefits requirement. The rule also ensures that issuers[1] formularies are developed based on expert recommendations.

The rule improves meaningful access standards by requiring that all Marketplaces, QHP issuers, and web brokers provide telephonic interpreter services in at least 150 languages in addition to the existing requirements regarding the provision of oral interpretation services, and strengthens other requirements related to language access.

To enhance the consumer experience for the Small Business Health Options Program (SHOP), the rule seeks to streamline the administration of group coverage provided through SHOP and to align SHOP regulations with existing market practices.