THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

February 4, 2014

The Honorable Jeanne Shaheen
United States Senate
Washington, DC 20510

Dear Senator Shaheen:

Thank you for your letter concerning network adequacy standards for qualified health plans (QHPs). I appreciate your insight and input on this matter.

The Marketplace will vastly increase uninsured Americans' access to providers, giving them more options for care, including an alternative to the emergency room. In addition, for the first time, there are now federal standards that require health plans to include a sufficient network of providers as well as essential community providers.

Pursuant to the *Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers* regulations at 45 C.F.R. 156.230(a)(2), QHP networks must have a sufficient number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that enrollees can access all services without unreasonable delay. All QHP issuers must attest that the plan meets this standard in order for the QHP to be certified or recertified.

The Centers for Medicare & Medicaid Services (CMS) intends to implement different procedures in the Federally-facilitated Marketplaces (FFMs) for determining whether a plan meets this standard from those used for the 2014 benefit year. As discussed in the *Draft 2015 Letter to Issuers in the Federally-facilitated Marketplace* issued today, issuers would be required to submit a provider list that includes all in-network providers and facilities for all plans for which a QHP certification application is submitted in the 2015 benefit year. Unlike the certification process for benefit year 2014, however, CMS no longer intends to rely on issuer accreditation status, identify states with review processes at least as stringent as those identified in 45 C.F.R. 156.230(a), or collect network access plans as part of its evaluation of issuers' network adequacy. Rather, CMS intends to use a "reasonable access standard" review standard and to identify networks that fail to provide access without unreasonable delay as required by 45 C.F.R. 156.230(a)(2). In order to determine whether an issuer meets this standard, CMS would focus most closely on those parts of the network, such as hospital systems, that have historically raised network adequacy concerns.

If CMS were to determine that an issuer's network was inadequate under reasonable access review, CMS intends to notify the issuer of the identified problem area(s) and consider the issuer's response prior to making the certification or recertification determination. CMS will share information and coordinate with states that are conducting network adequacy reviews and

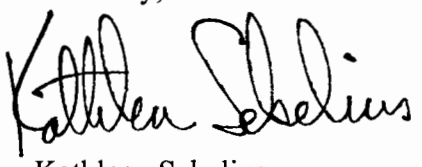
will use information learned during the comment period and network adequacy review process to articulate in future regulations more detailed network adequacy standards, including time and distance standards.

CMS believes it is critical for QHPs to provide accurate information regarding in-network providers. In accordance with 45 CFR 156.230(b), issuers must make their current provider directories available to the Marketplaces. In the Draft 2015 Letter to Issuers, CMS reiterated to issuers that their websites should link directly to provider directories and that enrollees and prospective enrollees should be able to view complete, accurate, and up-to-date directories without logging in or entering a policy number.

With regard to transparency reporting, 45 CFR 155.1040(a) and 156.220 require QHP issuers to submit specific information to the Marketplace and other entities in a timely and accurate manner. However, because QHP issuers will not have some of the data necessary for reporting under this requirement until during or after the first year of operation of their QHPs (e.g., QHP enrollment and disenrollment), CMS clarified in the Draft 2015 Letter to Issuers that, in order to comply with section 1311(e)(3) of the Affordable Care Act, QHP issuers will begin submitting information only after QHPs have been certified as QHPs for one benefit year. Additional details on the implementation of the transparency in coverage reporting requirements will be provided to issuers in future guidance.

I appreciate your commitment to making sure that American families have access to quality, affordable coverage. Thank you for your leadership on this particular issue, and I look forward to continuing to work with you as we implement the Affordable Care Act. Please do not hesitate to contact me with any further thoughts or concerns.

Sincerely,



Kathleen Sebelius