

item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information must be made available to such individual through an Internet Web site and such other means for individuals without access to the Internet.

§ 156.225 Marketing and Benefit Design of QHPs.

A QHP issuer and its officials, employees, agents and representatives must—

(a) *State law applies.* Comply with any applicable State laws and regulations regarding marketing by health insurance issuers; and

(b) *Non-discrimination.* Not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

§ 156.230 Network adequacy standards.

(a) *General requirement.* Each QHP issuer that uses a provider network must ensure that the provider network consisting of in-network providers, as available to all enrollees, meets the following standards—

(1) Includes essential community providers in accordance with § 156.235;

(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,

(3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

(b) *Access to provider directory.* (1) A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from HHS and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.

(2) For plan years beginning on or after January 1, 2016, a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information,

specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM. A provider directory is easily accessible when—

(i) The general public is able to view all of the current providers for a plan in the provider directory on the issuer's public Web site through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and

(ii) If a health plan issuer maintains multiple provider networks, the general public is able to easily discern which providers participate in which plans and which provider networks.

(c) *Increasing consumer transparency.* A QHP issuer in a Federally-facilitated Exchange must make available the information described in paragraph (b) of this section on its Web site in an HHS specified format and also submit this information to HHS, in a format and manner and at times determined by HHS.

(d) *Provider transitions.* A QHP issuer in a Federally-facilitated Exchange must—

(1) Make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal;

(2) In cases where a provider is terminated without cause, allow an enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.

(i) For the purposes of paragraph (d)(2) of this section, active course of treatment means:

(A) An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

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(B) An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;

(C) The second or third trimester of pregnancy, through the postpartum period; or

(D) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

(ii) Any QHP issuer decision made for a request for continuity of care under paragraph (d)(2) of this section must be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable State or Federal law or regulations.

(e) *Out-of-network cost sharing.* Beginning for the 2018 and later benefit years, for a network to be deemed adequate, each QHP that uses a provider network must:

(1) Notwithstanding § 156.130(c), count the cost sharing paid by an enrollee for an essential health benefit provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing; or

(2) Provide a written notice to the enrollee by the longer of when the issuer would typically respond to a prior authorization request timely submitted, or 48 hours before the provision of the benefit, that additional costs may be incurred for an essential health benefit provided by an out-of-network ancillary provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

[77 FR 18469, Mar. 27, 2012, as amended at 80 FR 10873, Feb. 27, 2015; 81 FR 12349, Mar. 8, 2016]

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§ 156.235 Essential community providers.

(a) *General ECP standard.* (1) A QHP issuer that uses a provider network must include in its provider network a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A plan applying for QHP certification to be offered through a Federally-facilitated Exchange has a sufficient number and geographic distribution of ECPs if it demonstrates in its QHP application that—

(i) The network includes as participating practitioners at least a minimum percentage, as specified by HHS, of available essential community providers in each plan's service area. For plan years beginning prior to January 1, 2018, multiple providers at a single location will count as a single essential community provider toward both the available essential community providers in the plan's service area and the issuer's satisfaction of the essential community provider participation standard. For plan years beginning on or after January 1, 2018, multiple contracted or employed full-time equivalent practitioners at a single location will count toward both the available essential community providers in the plan's service area and the issuer's satisfaction of the essential community provider participation standard; and

(ii) The issuer of the plan offers contracts to—

(A) All available Indian health care providers in the service area, applying the special terms and conditions required by Federal law and regulations as referenced in the recommended model QHP addendum for Indian health care providers developed by HHS; and

(B) At least one ECP in each of the ECP categories (Federally Qualified Health Centers, Ryan White Providers, Family Planning Providers, Indian Health Care Providers, Hospitals and other ECP providers) in each county in the service area, where an ECP in that