Health Care Reform
Bulletin

HHS Issues Proposed Notice of Benefit and Payment Parameters for 2017

Provided by Cottingham & Butler

Quick Facts

- On Dec. 2, 2015, HHS published its 2017 Notice of Benefit and Payment Parameters Proposed Rule.
- The proposed rule would increase the cost-sharing limitation for non-grandfathered plans in 2017.
- The proposed rule identifies the annual enrollment period for the 2017 benefit year.
- The rule also includes a new Exchange model and standardized plan options in the FFE.

The proposed Notice of Benefit and Payment Parameters for 2017 includes a variety of changes for 2017, including a new Exchange model and standardized benefit plan options in the FFE.

On Dec. 2, 2015, the Department of Health and Human Services (HHS) published its proposed **Notice of Benefit and Payment Parameters for 2017**. This proposed rule describes benefit and payment parameters under the Affordable Care Act (ACA), applicable for the 2017 benefit year, including standards relating to:

- Annual limitations on cost-sharing; and
- The open enrollment period in the Exchange for 2017.

In addition, the proposed rule includes the following key changes for 2017:

- Incorporates new definitions of "large employer" and "small employer," consistent with the Protecting Affordable Coverage for Employees (PACE) Act;
- Recognizes a new Exchange model; and
- Creates standardized benefit plan options in the federally facilitated Exchange (FFE).

HHS may make changes to the proposed rule before finalizing it. However, the proposed rule is a good indicator of the benefit and payment parameters that HHS may adopt for 2017.

Annual Limitations on Cost-sharing

Effective for plan years beginning on or after Jan. 1, 2014, the ACA requires non-grandfathered plans to comply with an overall annual limit—or an out-of-pocket maximum—on essential health benefits (EHB).

The ACA requires the out-of-pocket maximum to be updated annually based on the percent increase in average premiums per person for health insurance coverage.

- For 2016, the out-of-pocket maximum is **$6,850 for self-only coverage** and **$13,700 for family coverage**.
- Under the proposed rule, the out-of-pocket maximum would increase for 2017 to **$7,150 for self-only coverage** and **$14,300 for family coverage**.

Large Employer and Small Employer Definitions

As it was passed, the ACA included the following definitions of the terms "large employer" and "small employer":

- **Large Employer**—employed an average of at least 101 employees on business days during the preceding calendar year, and employs at least one employee on the first day of the plan year

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- **Small Employer**—employed an average of between one and 100 employees on business days during the preceding calendar year, and employs at least one employee on the first day of the plan year

Prior to Jan. 1, 2016, the ACA allowed states to elect to define a "large employer" as one with more than 50 employees, and "small employer" as one with 50 or fewer employees. However, these definitions were amended by the **PACE Act** on Oct. 7, 2015. Therefore, the proposed rule would revise the regulatory definitions of "large employer" and "small employer" to conform to the PACE Act. Specifically:

- The definition of "large employer" would be revised to mean an employer with an average of **at least 51 employees** during the preceding calendar year.

- The definition of "small employer" would be revised to mean an employer with an average of between **one and 50 employees** during the preceding calendar year.

However, the proposed rule would allow states to elect to define a "large employer" as one with more than 100 employees, and a "small employer" as one with 100 or fewer employees.

The proposed rule would also clarify that an employer that was not in existence during the preceding calendar year would determine whether it is a "large employer" or "small employer" based on the average number of employees that it is reasonably expected to employ during the current calendar year.

Small Business Health Options Program (SHOP)
For 2015, employers offering coverage through a federally facilitated SHOP (FF-SHOP) have two options for providing coverage—they can offer:

- A single plan; or

- A "horizontal" choice, where an employer selects a single actuarial value coverage level and makes all plans at that coverage level available to the qualified employees.

For plan years beginning on or after Jan. 1, 2017, the proposed rule would add an additional employer choice option in FF-SHOPs, called a "vertical choice" option. This vertical choice would allow employers to offer qualified employees a choice of all plans across all available levels of coverage from a single issuer. State-based SHOPs would have the flexibility to provide employers with vertical choice, or other options for providing employer choice in addition to "horizontal" choice.

Exchange Open Enrollment Period for 2017
The proposed rule identifies the annual open enrollment period for non-grandfathered policies in the individual market, inside and outside of the Exchange, for 2017.

Under the proposed rule, the annual open enrollment period for 2017 would remain the same as it was for 2016. Thus, the 2017 open enrollment period would begin on **Nov. 1, 2016**, and run through **Jan. 31, 2017**.

The proposed rule also briefly addresses the open enrollment period for the 2018 benefit year. Although HHS did not specify dates for the 2018 open enrollment period, it is considering whether to shift to an earlier open enrollment period, such as Oct. 15, and either:

- Maintain the same duration, so that the 2018 open enrollment period would run from Oct. 15, 2017 – Jan. 15, 2018; or

- Shorten the duration, so that the open enrollment period for 2018 would run from Oct. 15, 2017 – Dec. 15, 2017.

HHS requested comments on the length, start date and end date of the open enrollment period for 2018 and subsequent years.

New Category of Exchange
Under the ACA, states could choose one of the following three models for their Exchange:

- Create and operate their own **state-based Exchange (SBE)**;

- Have HHS operate an **FFE** for its residents; or

- Partner with HHS to create a **partnership Exchange**, so that some FFE functions are performed by the state.

The proposed rule would add an additional Exchange model—**a state-based Exchange on the federal platform (SBE-FP)**—to enable SBEs to conduct certain processes using the federal eligibility and enrollment infrastructure on www.healthcare.gov. Under the proposal:

- The SBE-FP would continue to be primarily responsible for plan management functions, consumer assistance, and ongoing oversight and program integrity.
- HHS would be responsible for eligibility and enrollment functions, certain consumer call center functions and casework processes, and maintaining related IT infrastructure.

Currently, four states—Hawaii, Oregon, Nevada and New Mexico—have established SBEs that rely on the www.healthcare.gov platform.

Standardized Plan Options

The proposed rule creates **six "standardized benefit plan options"** in the individual market FFE, in an effort to simplify the plan selection process by allowing consumers to more easily compare plans across issuers in the FFE. These standardized options would include:

- One bronze standardized option;
- One silver standardized option;
- A separate standardized option for each silver plan variation (73 percent, 87 percent and 94 percent) available to individuals who are eligible for cost-sharing reductions; and
- One gold standardized option.

These plans would have a single provider tier, a fixed in-network deductible, a fixed annual cost-sharing limit and standardized copayments and coinsurance for a key set of EHB that comprise a large percentage of the total allowable costs for an average enrollee.

Under this proposal, issuers would not be required to offer standardized options in 2017, and would still be permitted to offer non-standardized plans. HHS intends to propose standardized option changes annually, and requests comments on these proposals.

Individual Mandate's Affordability Exemption

Under the ACA, individuals who lack access to affordable minimum essential coverage (MEC) are exempt from the individual mandate penalty. For purposes of this exemption, coverage is considered affordable for an employee if the required contribution for the lowest-cost, self-only coverage does not exceed **8 percent of household income**.

This required contribution percentage is adjusted annually after 2014. For 2015, the required contribution percentage is **8.05 percent of household income**. For 2016, the required contribution percentage is **8.13 percent of household income**.

For 2017, the proposed rule provides that an individual is exempt from the individual mandate penalty if he or she must pay more than **8.16 percent of his or her household income** for MEC.

Medical Loss Ratio Rules

The ACA's medical loss ratio (MLR) rules require health insurance issuers to spend 80 to 85 percent of their premium dollars on medical care and health care quality improvement activities, or pay rebates to enrollees.

Previous MLR regulations required issuers to report incurred claims within a **three-month run-out period**. This run-out period is intended to improve the accuracy of reported incurred claims by using actual claims payments that take place during the run-out period—instead of estimated claims liabilities and reserves—in the calculation of claims incurred in the reporting year.

However, MLR reports are not due to HHS until **July 31** of the year following the reporting year. Because of this, the proposed rule notes that

the incurred claims valuation can occur later in the year in order to provide a more accurate MLR calculation by reducing reliance on estimates.

Thus, the proposed rule would amend the reporting requirements for incurred claims to use a **six-month** run-out period (rather than three-month), beginning with the 2015 reporting year. This proposed amendment would require incurred claims to be calculated as of June 30 (rather than March 31) of the year following the reporting year.

In addition, in the proposed rule, HHS invites comments on whether an issuer should be **permitted to count investments in fraud-prevention activities as incurred claims** for MLR reporting purposes. Currently, issuers are only permitted to include amounts recovered through fraud-reduction efforts, up to the amount of fraud-reduction expenses, in incurred claims when calculating the MLR.

Source: Department of Health & Human Services