

Final HHS Notice of Benefit and Payment Parameters for 2017 Fact Sheet

The final HHS Notice of Benefit and Payment Parameters for 2017 released today sets standards for issuers and Health Insurance Marketplaces for plan years beginning on or after January 1, 2017. It generally includes payment parameters that will apply to the 2017 benefit year, establishes new standards to improve consumers' Marketplace experience, promotes continuity and stability in the Marketplaces, and ensures coverage is affordable and accessible.

Open enrollment for the 2016 benefit year recently concluded with about 12.7 million people actively selecting a plan or being auto re-enrolled for 2016. In addition, about 400,000 people signed up for New York's and Minnesota's Basic Health Programs, State-based programs supported by the Affordable Care Act that provide health insurance coverage to low-income individuals, many of whom would otherwise be eligible to buy qualified health plans (QHPs) on the Marketplace.

Some of the policies in the final rule released today include:

Payment Parameters

Risk Adjustment Model Recalibration: Risk adjustment factors that reflect enrollee health risk are developed using claims data and reflect the costs of a given disease relative to average spending for treatment. The longer the lag in data used to develop the risk factors, the more potential that the costs of treating one disease versus another will change over time and not be reflected in the risk factors. To mitigate this effect, while maintaining stability in our model parameters, we will update the benefit year 2017 risk adjustment factors to reflect multiple years of claims data (2012, 2013, and 2014), as we did for benefit year 2016. To better address the data lag and more accurately account for conditions with high-cost treatments, we will also trend specialty and traditional drug expenditures at separate growth rates from medical expenditures. In previous years, we had used the same growth rate for medical and drug expenditures. We will also incorporate preventive services into our simulation of plan liability in the recalibration of the risk adjustment models for the 2017 benefit year.

Small Issuer Rule for Default Risk Adjustment Charge: We finalized a separate, lower default risk adjustment charge beginning for the 2016 benefit year for small issuers, defined as issuers with 500 or fewer billable member months in a state's individual and small group markets, in recognition of the disproportionately high administrative costs of setting up an EDGE server relative to the transfers that would occur.

Default Risk Adjustment Charge: We will raise the default risk adjustment charge from the 75th percentile to the 90th percentile of absolute transfers nationwide as a percent of state average premium beginning in the 2015 benefit year. This adjustment aims to encourage continued compliance with risk adjustment data submission requirements.

FFM User Fee for 2017: We will charge a Federally-facilitated Marketplaces (FFM) user fee rate of 3.5% of premium for 2017, a rate calculated to cover user fee-eligible costs. This user fee rate is the same as the rate for each year from 2014 through 2016. We will charge issuers operating in a State-based Marketplace on the Federal platform (SBM-FP) a reduced user fee rate of 1.5% of premium for the 2017 benefit year, to ease the transition for SBM-FP States, and will allow additional flexibility in the assessment of these charges for those States.

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Premium Adjustment Percentage: This percentage generally measures the average health insurance premium increase since 2013, based on the most recent National Health Expenditures Accounts projection of per enrollee employer-sponsored insurance premiums. The premium adjustment percentage is used to set the rate of increase for three key parameters: the maximum annual limitation on cost sharing, the required contribution percentage for eligibility for a hardship exemption under section 5000A of the Code, and the affordability percentage for calculation of assessable payment amounts under section 4980H(a) and (b) of the Code. For 2017, the premium adjustment percentage is approximately 13.3%, covering increases over the three year period from 2014 to 2017 (an average annual rate of 4.3%).

Annual Limitation on Cost Sharing: The maximum annual limitation on cost sharing is the product of the dollar limit for calendar year 2014 (\$6,350 for self-only coverage) and the premium adjustment percentage for 2017, rounded down to the next lower \$50. The 2017 maximum annual limitation on cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage.

Market Rules

Student Health Insurance Plans: Under this rule, issuers of student health insurance plans may establish one or more separate risk pools for each college or university, but the risk pools must be based on a bona fide school-related classification and not on health status. The premium rates for each risk pool must reflect the claims experience of individuals who comprise the risk pool, and any adjustments to rates within a risk pool must be actuarially justified. Also, we eliminate the requirement for student health insurance plans to offer coverage within specific metal levels, and instead require student health insurance plans to offer an actuarial value of at least 60%.

Rate Review: We are requiring all issuers to submit the unified rate review template (URRT) for all single risk pool products in the individual and small group markets (excluding student health plans) regardless of whether they propose rate increases, rate decreases, or no change in rates for these products.

Eligibility, Enrollment, and Benefits

Annual Open Enrollment Period: We are finalizing the open enrollment period for the individual market Marketplaces for benefit years 2017 and 2018 to correspond to the open enrollment period for the 2016 benefit year, meaning it will begin on November 1 of the year preceding the benefit year and run through January 31 of the benefit year. We also finalized the open enrollment period for benefit year 2019 and later benefit years, so that it will begin on November 1 and run through December 15 of the year preceding the benefit year. This policy will provide continuity in the short run and sufficient time for all entities involved in the annual open enrollment period process, including Exchanges and issuers, to make the necessary adjustments to meet this earlier deadline.

State-based Marketplaces Using the Federal Platform: Today, a few State-based Marketplaces (SBMs) rely on HealthCare.gov's technology for eligibility and enrollment functions for individual market enrollments. In future years, additional States may wish to use the federal information technology (IT) platform for eligibility and enrollment functions for their individual and/or SHOP Marketplaces. We are

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codifying a Marketplace model for these States, the State-based Marketplaces on the Federal platform (SBM-FPs). The SBM-FPs will retain primary responsibility for plan management functions, consumer assistance and outreach, ongoing oversight and program integrity, and for ensuring that all Marketplace requirements are met, but will agree to rely on the Federal platform for eligibility determinations and enrollment processing activities, and associated Federal platform services. We will collect user fees to cover Federal costs in these States. Finally, we are finalizing the requirement that SBM-FPs enforce certain QHP and QHP issuer requirements that are no less strict than the requirements that HHS applies to QHPs and QHP issuers in the FFMs, along with the authority of HHS to suppress plans on HealthCare.gov in appropriate circumstances.

Standardized Options: To simplify the shopping experience for consumers on the individual market Federally-facilitated Marketplaces, we are finalizing the proposal to designate plans with certain standardized cost-sharing structures as “standardized options.” Plans with standardized cost-sharing structures will give consumers the opportunity to more easily compare plans offered by different issuers within a metal level, and can simplify the consumer shopping experience. We have developed 6 specific recommended designs (1 silver, which would be coupled with 3 silver cost-sharing reduction variations, 1 bronze, and 1 gold). It is optional for issuers to offer standardized options. We are carrying out consumer testing to determine how such plans will be displayed on HealthCare.gov.

Network Adequacy (Continuity of Care): We finalized two provisions regarding continuity of care applicable to QHPs on FFMs. First, we require the issuer to provide written notice to all enrollees who are patients seen on a regular basis by the provider or receive primary care from the provider of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable. Second, we require the issuer, in cases where a provider is terminated without cause, to allow enrollees in active treatment to continue treatment until the treatment is complete or for 90 days (whichever is shorter) at in-network cost-sharing rates. The provision is limited to specific cases where the enrollee is in active treatment.

Network Adequacy (Cost Sharing): Under this rule, beginning in 2018, issuers must count the cost sharing charged to the enrollee for certain out-of-network services provided at an in-network facility by an ancillary provider towards the enrollee’s annual limitation on cost sharing. The exception to this requirement is if the issuer provides 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 prior to the service that an out-of-network ancillary provider may be providing these services and that the enrollee may incur additional costs. This provision aims to limit “surprise bills” to consumers.

Network Adequacy (Transparency): With the goal of starting in 2017, HealthCare.gov plans to include a rating of each QHP’s relative network coverage. This rating will be made available to a consumer when making a plan selection, and will help an enrollee select the plan that best meets his or her needs. This summary measure will be developed by comparing the breadth of the QHP network at the plan level to the breadth of the other plan networks for plans available in the same geographic area.

Third-party Payments: We update provisions from our previous Interim Final Rule regarding third party payments (IFR) to clarify that “State and Federal Government programs” include programs of the political subdivisions of the State, namely counties and municipalities, or local government programs. We also finalize that while issuers offering individual market QHPs, including SADPs, generally do not

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collect cost-sharing payments, downstream entities, such as PBMs, are required to accept third party cost-sharing payments on behalf of enrollees from the entities identified in the IFR (i.e. State and Federal Government Programs, Ryan White HIV/AIDS programs and Indian Tribes, Tribal Organizations and Urban Indian Organizations) in circumstances where the issuer's downstream entity (e.g., pharmacy benefits manager) accepts cost-sharing payments from plan enrollees. We are not finalizing the proposed information collection that would have required entities from which QHP issuers are required to accept third party premium payments to provide estimates of enrollees being assisted to HHS.

QHP Patient Safety Requirements: We finalize a requirement that a QHP issuer offering coverage through the Marketplaces may only contract with a hospital with more than 50 beds if the hospital: (a) participates with a Patient Safety Organization; or (b) meets the reasonable exception standard by implementing an evidence-based initiative to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission, or improves care coordination (i.e., hospital participation and tracking documentation such as hospital attestations or current agreements to partner with Hospital Engagement Networks; and Quality Innovation Networks-Quality Improvement Organizations).

SHOP: We are adding a third employee choice option under which employers will have the option of offering all plans across all actuarial value levels from one issuer ("vertical choice"). We are finalizing the addition of this vertical choice option in the Federally-facilitated SHOPS (FF-SHOPs) for plan years beginning on or after January 1, 2017, but will give States with FF-SHOPs an opportunity to recommend that the FF-SHOP in their State not offer vertical choice in their State. States with SBE-FPs utilizing the Federal platform for SHOP enrollment functions will be able to opt out of making vertical choice available in their States. SHOPS in all states would continue to be required to permit employers to offer a choice of all QHPs at a single actuarial value level of coverage.

Post-enrollment Assistance and Other Requirements for Assisters: We are expanding the required duties of FFM Navigators to include specific post-enrollment and other assistance activities such as helping consumers understand the basic process of filing Marketplace eligibility appeals, helping consumers understand and apply for exemptions from the individual shared responsibility payment that are granted through the Marketplace, and helping consumers understand basic concepts and rights related to health coverage and how to use it. These duties will be required in FFMs beginning with Navigator grants awarded in 2018, and State-based Marketplaces will have the option of requiring or authorizing them. In addition, we require Navigators to provide targeted assistance to vulnerable or underserved populations in the Marketplace service area, and permit each Marketplace to define and identify the underserved and vulnerable populations its Navigators will target. We are also finalizing that Navigators and non-Navigator assistance personnel are required to complete training prior to performing outreach and education activities as well as prior to providing application or enrollment assistance. Lastly, we finalize that certified application counselor designated organizations must provide the Marketplace in which they serve metrics related to the number and performance of the organization's certified application counselors, at the Marketplace's request.

Direct Enrollment Enhancements and Agent and Broker FFM Enforcement: We are establishing a framework to support the use of an expanded direct enrollment pathway option for web-brokers and QHP issuers in 2018 and future coverage years under which an applicant may remain on the web-broker's or issuer's non-FFM website to complete the Marketplace application and enroll in coverage.

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We intend to supplement the framework we are finalizing with more specific guidance and requirements in future rulemaking. Until then, entities must continue to comply with the current direct enrollment process. We also established standards for terminating or suspending agreements between agents and brokers and the FFM in cases of fraud or abusive conduct that may cause imminent or ongoing consumer harm; for providing notice to States of those suspension and termination actions; governing the conduct of FFM-registered agents and brokers to better protect consumers and ensure the efficient operation of the FFMs; and providing for penalties other than terminations of the agent's or broker's FFM agreements.