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

The proposed HHS Notice of Benefit and Payment Parameters released today proposes key standards for issuers and Health Insurance Marketplaces for 2017. It generally includes payment parameters that would apply to the 2017 benefit year, and proposes new standards to improve consumers' Marketplace experience and ensure coverage is affordable and accessible.

Open enrollment for coverage in 2016 is currently underway, and consumers are shopping and enrolling at HealthCare.gov. Today's proposed rule addresses standards that would apply to coverage available to consumers in 2017.

Some of the policies in today's proposed rule 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. 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 some stability in our model parameters in the initial years of risk adjustment, we are proposing to update the benefit year 2017 risk adjustment factors that were recalibrated for the 2016 benefit year using multiple years of Truven MarketScan claims data (2011, 2012, and 2013 MarketScan). Similar to last year, we propose that when 2014 MarketScan data becomes available in December 2015, we may recalculate these factors using a data set that will incorporate the 2014 data for publication in the final 2017 Payment Notice. We are proposing to incorporate preventive services into our simulation of plan liability in the recalibration of the risk adjustment models for the 2017 benefit year. We also seek comment on other improvements to HHS's risk adjustment methodology.

Small Issuer Rule for Default Risk Adjustment Charge: We propose 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 combined in a benefit year, in recognition of the disproportionally high administrative costs of setting up an EDGE server relative to the transfers that would occur. We believe that this proposal would have a minimal impact on risk transfers.

Default Risk Adjustment Charge: We propose to 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 prevent the charge from being a low-cost option for issuers. Additionally, we propose to codify guidance regarding how the default charge may be applied when issuers set up EDGE servers, but fail to meet data sufficiency standards.

FFM User Fee for 2017: We propose a Federally-facilitated Marketplaces (FFM) user fee rate of 3.5% 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 2014-2016. We also propose a user fee rate of 3.0% for State-based Marketplaces utilizing the federal platform (SBM-FP) to generate funding to support FFM operations associated with providing these services. We are considering reducing the SMB-FP user fee rate for the 2017 benefit year to ease the transition for States, and offering to collect a user fee on behalf of the SMB-FP at their discretion.

Premium Adjustment Percentage: This percentage measures the premium increase since 2013, based on the most recent National Health Expenditures Accounts (NHEA) projection of per enrollee employer-sponsored insurance (ESI) premiums for 2016. 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, we propose a premium adjustment percentage of approximately 13.2%, covering the three year period from 2014 to 2017.

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. The 2017 maximum annual limitation on cost sharing would be $7,150 for individual coverage and $14,300 cumulative for family coverage.

Market Rules

Student Health Insurance Plans: We propose to subject issuers of student health insurance plans to the single risk pool index rating methodology, although they may establish one or more separate risk pools for each college or university, provided the risk pools are based on a bona fide school-related classification and not based on a health status related factor. Also, we propose to eliminate the requirement for student health insurance plans to offer coverage within specific metal levels, and instead would require student health insurance plans to offer an actuarial value of at least 60%.

Rate Review: We propose to require 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 propose to set the open enrollment period for the individual market Marketplace for benefit year 2017 to correspond to the 2016 benefit year, meaning it will begin on November 1, 2016 and end on January 31, 2017.

State-based Marketplaces Using the HealthCare.gov Platform: Today, a number of State-based Marketplaces (SBEs) rely on HealthCare.gov's technology to fulfill certain requirements related to individual market eligibility and enrollment. In future years, additional states may wish to use the federal information technology (IT) platform for eligibility and enrollment for their individual and/or SHOP Marketplaces. We are proposing that these Marketplaces be known as SBMs on the Federal platform (SBM-FPs). These SBM-FPs retain primary responsibility to ensure all Marketplace requirements are met, but may do so through reliance on the FFM for its eligibility determinations and enrollment processing activities, as well as certain consumer call center services. The SBM-FPs also retain primary responsibility for performing all other Marketplace functions, including plan management, consumer assistance and outreach functions, and ongoing oversight and program integrity. We propose collecting user fees directly from QHP issuers operating in SBM-FP states, ensuring that SBM-FPs apply certain FFM QHP standards to their issuers, and coordinating with SBM-FPs to enforce those QHP standards on SBM-FP issuers.

Re-Enrollment Hierarchy: To minimize potential disruptions of enrollee eligibility for cost-sharing reductions, we propose to amend §155.335(j)(1) to reconfigure the re-enrollment hierarchy for all enrollees in a silver-level qualified health plan (QHP) that is no longer available for re-enrollment. Specifically, if such an enrollee's current silver-level QHP is not available and the enrollee's current product no longer includes a silver-level QHP available through the Marketplace, the enrollee's coverage would be renewed in a silver–level QHP in the product offered by the same issuer that is the most similar to the enrollee may elect to have their current product, rather than in a plan one metal level higher or lower than his or current silver-level QHP, but within the same product.

Hardship Exemptions: Consistent with prior guidance, we propose to permit any applicant whose gross income is below the filing threshold to qualify for a hardship exemption and claim the exemption through the tax filing process. Additionally, consistent with prior guidance, we propose starting to permit individuals eligible for services from an Indian health care provider to claim a hardship exemption through the tax filing process. We also propose to codify other hardship exemptions previously announced in prior guidance and to clarify operational standards for age of hardship events and length of certain hardship exemptions.

Standardized Options: To simplify the shopping experience for consumers on the individual market Federally-facilitated Marketplaces, we propose to designate plans with certain standardized cost-sharing structures as "standardized options." 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). We propose making it optional for issuers to offer standardized options, and allowing issuers to offer non-standardized plans as well. 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 are considering ways that such plans could be displayed on HealthCare.gov in a manner that makes it easier for consumers to find and consider them.

Improving Product Value: We propose and seek comment on HHS's current authority to deny certification to qualified health plans (QHPs) that we determine are not in the interest of consumers, even if the QHPs otherwise meet minimum certification requirements. We would focus denials of certification in the FFMs based on the "interest of the qualified individuals and qualified employers" standard on cases involving the integrity of the FFMs and the plans offered through them. Examples of issues that could result in non-certification of a plan include concerns related to an issuer's material non-compliance with applicable requirements, an issuer's financial insolvency, or data errors related to QHP applications and data submissions.

Network Adequacy (Minimum Threshold): We propose that a network adequacy standard be selected by the state in which an FFM is operating, subject to certain minimum criteria established by HHS. We anticipate that states would select among a certain number of the metrics articulated in the *Letter to Issuers*. If a state does not select one of the applicable metrics, we propose to apply a default time and distance standard to issuers applying for QHP certification in an FFM. We also seek comment on whether to improve transparency by designating network strength, to support more informed consumer decision-making. Our proposals on network adequacy and continuity of coverage reflect the policy deliberations of the National Association of Insurance Commissioners (NAIC).

Network Adequacy (Continuity of Care): We propose two provisions regarding continuity of care applicable to QHPs on Federally-facilitated Marketplaces. First, we propose to require the issuer to provide written notice to enrollees of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable. Second, we propose to require the issuer, in cases where a provider is terminated without cause, to allow an affected enrollee to continue treatment until the treatment is complete or for 90 days (whichever is shorter) at in-network cost-sharing rates. The provision would be specific to cases where the enrollee is in active treatment.

Network Adequacy (Cost Sharing): We propose that issuers must count the cost sharing charged to the enrollee for certain out-of-network services (provided at an in-network facility) towards the enrollee's annual limitation on cost sharing. The exception to this requirement would be if the issuer provides 10 days' notification to the enrollee that an out-of-network provider may be providing these services and that the enrollee may incur additional costs. This proposal aims to limit "surprise bills" to consumers.

Third-party Payments: We update provisions from our previous IFR to clarify that "State and Federal Government programs" include programs of the political subdivisions of the State, namely counties and municipalities. We also propose to clarify that while issuers offering individual market QHPs, including SADPs, generally do not collect cost-sharing payments, they are required to accept third party cost-sharing payments on behalf of enrollees in circumstances where the issuer or the issuer's downstream entity (e.g., pharmacy benefits manager) accepts cost-sharing payments from plan enrollees. Lastly, we propose that entities making such third party payments of premiums must provide certain information to HHS.

QHP Patient Safety Requirements: We propose: (a) requiring QHP issuers offering coverage through the Marketplaces to track hospital agreements with Patient Safety Organizations; and (b) providing an exception to the requirement that a QHP issuer may only contract with a hospital with more than 50 beds if the hospital contracts with a Patient Safety Organization. These exceptions include allowing QHP issuers to contract with hospitals that implement evidence-based initiatives to reduce all cause preventable harm, prevent hospital readmission, improve care coordination and improve health care quality through the collection, management and analysis of patient safety events (i.e., hospital participation and tracking agreements with Hospital Engagement Networks; and Quality Innovation Networks-Quality Improvement Organizations).

SHOP: We propose to add a third employee choice option for the Federally-facilitated SHOPs, and seek comment on whether to add a fourth, for plan years beginning on or after January 1, 2017. Under the third option, employers would have the option of offering all plans across all actuarial value levels from one issuer ("vertical choice"). Under the fourth option, employers would be able to select an actuarial value level of coverage and employees could choose from plans available at that level and at the level above it ("two contiguous levels of coverage option"). We are also seeking comment on whether states with a Federally-facilitated SHOP should have the opportunity to decide whether additional models of employee choice should be made available in their state. SHOPs in all states would continue to be required to permit employers to offer a choice of all QHPs at a single level of coverage.

Post-enrollment Assistance and Other Requirements for Assisters: We propose to expand the required duties of Navigators to include specific post-enrollment and other assistance activities such as helping consumers file Marketplace eligibility appeals, apply for exemptions through the Marketplace, and navigate the transition from coverage to care. In addition, we propose to require Navigators to target

vulnerable or underserved populations in the Marketplace service area, and to permit each Marketplace to define and identify the underserved and vulnerable populations in their region. We also propose that Navigators and non-Navigator assistance personnel would be required to complete training prior to performing outreach and education activities as well as prior to providing direct consumer assistance. Lastly, we propose that certified application counselor designated organizations must provide the Marketplace in which they serve with metrics related to the number and performance of the organization's certified application counselors.

Direct Enrollment Enhancements, Agent and Broker Enforcement, and Standards for HHS-Approved Vendors of FFM Training for Agents and Brokers: We seek comment on standards for web-brokers and QHP issuers under which an applicant may remain on the web-broker's or issuer's website to complete the Marketplace application and enroll in coverage. We also propose additional standards for terminating agreements between agents and brokers and the Federally-facilitated Marketplace (FFM), establish standards of conduct for FFM-registered agents and brokers to better protect consumers, and establish penalties other than terminations of the FFM agreements. Lastly, we propose eliminating the requirement that HHS-approved vendors of FFM training for agents and brokers perform information verification functions, including state licensure verification and identity proofing.