



Summary:

Proposed Notice of Benefit & Payment Parameters for 2017

QHP Certification Considerations

December 1, 2015

Agenda

- I. Overview of QHP Certification Topics
 - A. Meaningful Difference Standards
 - B. Cost Sharing
 - C. Standard Plans
 - D. Network Adequacy
 - E. Rate Review
 - F. State-Based Exchange on the Federal Platform
 - G. Enrollment Highlights
- II. Other Provisions

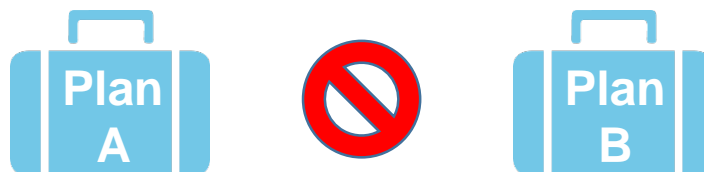


**Open enrollment period will run from
November 1, 2016 to January 31, 2017**

(the same timeline as the 2016 open enrollment period).

Meaningful Difference Standards

Plans are no longer meaningfully different if the only difference is:



- HSA eligible vs. not HSA eligible
- Self-Only vs. Non-Self-Only Coverage.

For the new standardized plan option (outlined in the following slide), HHS proposes that an issuer may offer multiple plans through the FFE for each standardized option within a service area when the plans are meaningfully different, such as offering an HMO standardized option and a PPO standardized option at a certain metal level.



All changes are currently **proposed** (not final); HHS is seeking comment on all proposed changes.

Cost Sharing

In line with the anticipated annual update, the permitted annual limitations on cost sharing have increased across all coverage levels—including for cost-sharing reduction plans:

Category	2016		2017	
	Self-Only	Other than Self-Only	Self-Only	Other than Self-Only
Maximum Annual Limit on Cost Sharing	\$6,850	\$13,700	\$7,150	\$14,300
Reduced Annual Limit on Cost Sharing for Individuals between 100 and 150% of the Federal Poverty Level (FPL)	\$2,250	\$4,500	\$2,350	\$4,700
Reduced Annual Limit on Cost Sharing for Individuals between 150 and 200% of the Federal Poverty Level (FPL)	\$2,250	\$4,500	\$2,350	\$4,700
Reduced Annual Limit on Cost Sharing for Individuals between 200 and 250% of the Federal Poverty Level (FPL)	\$5,450	\$10,900	\$5,700	\$11,400

Standard Plans

- To simplify the consumer plan-selection process, HHS is proposing to establish “standardized options” in the individual market FFEs
- Standardized options will have:
 - Single provider tier;
 - Fixed deductible;
 - Fixed MOOP;
 - Standardized copayments and coinsurance for a key set of EHBs.
- Issuers would not be required to offer them in 2017 and may also offer non-standardized plans.
- HHS invites comment on these plans and how these plans may interact with State-specific cost-sharing laws or regulations.

	Bronze	Silver	Silver 73% Actuarial Value Variation	Silver 87% Actuarial Value Variation	Silver 94% Actuarial Value Variation	Gold
Actuarial Value (%)	61.8	71.00	73.55	87.47	94.3	79.98
Deductible	\$6,650	\$3,500	\$3,000	\$700	\$250	\$1,250
Annual Limitation on Cost Sharing	\$7,150	\$7,150	\$5,700	\$2,000	\$1,250	\$4,750
Emergency Room Services	50%	\$400 (copay applies only after deductible)	\$300 (copay applies only after deductible)	\$150 (copay applies only after deductible)	\$100 (copay applies only after deductible)	\$250 (copay applies only after deductible)
Urgent Care	50%	\$75 (*)	\$75 (*)	\$40 (*)	\$25 (*)	\$65 (*)
Inpatient Hospital Services	50%	20%	20%	20%	5%	20%
Primary Care Visit	\$45 (* first 3 visits, then subject to deductible and 50% coinsurance)	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$20 (*)
Specialist Visit	50%	\$65 (*)	\$65 (*)	\$25 (*)	\$15 (*)	\$50 (*)
Mental Health/ Substance Use Disorder Outpatient Services	\$45 (*)	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$20 (*)
Imaging (CT/PET Scans, MRIs)	50%	20%	20%	20%	5%	20%
Rehabilitative Speech Therapy	50%	20%	20%	20%	5%	20%
Rehabilitative OT/PT	50%	20%	20%	20%	5%	20%
Laboratory Services	50%	20%	20%	20%	5%	20%
X-rays	50%	20%	20%	20%	5%	20%
Skilled Nursing Facility	50%	20%	20%	20%	5%	20%
Outpatient Facility Fee	50%	20%	20%	20%	5%	20%
Outpatient Surgery Physician/Surgical	50%	20%	20%	20%	5%	20%
Generic Drugs	\$35 (*)	\$10 (*)	\$10 (*)	\$5 (*)	\$3 (*)	\$10 (*)
Preferred Brand	50%	\$50 (*)	\$50 (*)	\$25 (*)	\$5 (*)	\$30 (*)
Non-Preferred Brand Drugs	50%	\$100 (*)	\$100 (*)	\$50 (*)	\$10 (*)	\$75 (*)
Specialty Drugs	50%	40% (*)	40% (*)	30% (*)	25% (*)	30% (*)

(*) = not subject to the deductible.

Network Adequacy

State Review of Network Adequacy

HHS would determine that a State's review is acceptable if the State selects standards from a list of metrics provided in the Letter to Issuers; HHS anticipates including at least the following metrics:

- Prospective time and distance standards at least as stringent as the FFE standard;
- Prospective minimum provider-covered person ratios for the specialties with the highest utilization rate for its State.

In States that do not review network adequacy, the FFE would conduct an independent review under a Federal default time and distance standard.

Other Proposed Changes

Issuer must make a good faith effort to provide notice of a discontinued provider 30 days prior to all enrollees who are patients seen on a regular basis;

- If the provider is terminated without cause, issuers must allow an enrollee in active treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.

Issuers must count cost sharing for an EHB provided by an out-of-network provider in an in-network setting towards the enrollee's annual limitation on cost sharing, **unless** the issuer provides enrollees with at least 10 business days' notice of potential additional costs.



Rate Review

- Starting in 2017, rate increases will be considered at the plan, not the product, level.
- Rather than considering the change to the index rate, the rules propose to consider the average increase for all enrollees (weighted by premium volume), factoring in the impact of premium rating factors

Issuers without any plan rate increases:

- ✓ Unified Rate Review Template (URRT)

Issuers with plan rate increases below the threshold:

- ✓ Unified Rate Review Template (URRT);
- ✓ Actuarial Memorandum.

Issuers with plan rate increases above the threshold:

- All parts of the Rate Filing Justification:
- ✓ Unified Rate Review Template (URRT);
 - ✓ Written description justifying the rate increase;
 - ✓ Actuarial Memorandum.

HHS proposes to post online public documents for all proposed and final rate increases, not just those subject to review, at a uniform time and will require States with Effective Rate Review Programs to do the same for plans on and off of the Exchange; HHS will announce the proposed timeline for doing so in December.

State-Based Exchange on the Federal Platform

SBE-FP refers to SBEs that rely on the Federal IT platform; these states must comply with Federal standards for items such as:

- plan compare;
- eligibility & enrollment requirements and timelines;
- premium estimator;
- second-lowest cost silver plan;
- premium and reconciliation regulations; and
- grace periods.

HHS proposes collecting a three percent Exchange user fee from QHP issuers in those States using the SBE-FP model (though may reduce that amount for 2017)

States interested in pursuing a SBE now have several deadlines to meet:

- Submit a declaration letter “approximately” 21 months ahead of the proposed first open enrollment period;
- Submission of a Blueprint at least 15 months ahead of open enrollment;
- Ultimately securing approval at least 14 months ahead of open enrollment.

These timelines are shorter for States pursuing SBE-FP status (declaration letter nine months in advance, submission of Blueprint at least three months in advance and approval two months in advance).

Re-Enrollment & Employee Choice

HHS has proposed changes to the hierarchy for automatic plan re-enrollment:

Current

Currently, individuals that are enrolled in a **product** that will not include a plan in the same metal level in the subsequent year will be automatically re-enrolled into a plan within the **same product** in a **different metal level**.

Proposed

The proposed rules would adjust that hierarchy so that those enrolled in **silver-level** QHPs whose plans are no longer offered on the Exchange will be auto-enrolled into another **silver-level** plan from the same carrier to protect eligibility for cost-sharing reductions.

HHS also noted that it is considering providing enrollees a choice at enrollment of whether to be automatically re-enrolled based on their current plan or the low-cost plan the following year.

HHS also proposed additions to the types of choice SHOP employers can offer to enrollees:

Vertical Choice

HHS is proposing “vertical (employee) choice,” described as the option of making available all plans across all metal levels from a single insurer.

Additional Choices

Additionally, HHS proposed to allow employers to offer a choice of any plan in a single actuarial level of coverage or the level above it, or simply allowing States in which an FFE is located to recommend additional models of employee choice.

Other Areas Addressed in the 2017 Proposed NBPP

- Risk Adjustment, Reinsurance and Risk Corridors;
- Guaranteed availability and withdrawal and guaranteed renewability;
- Consumer assistance and brokers / agents;
- Student health insurance;
- Patient safety;
- Issuer administrative appeals related to payments;
- Third-party payments of premiums and cost sharing; and
- Medical loss ratios.

Contact us

Margot Thistle

Senior Consultant

mthistle@pcgus.com

Lisa Kaplan Howe

Senior Advisor

lkaplanhowe@pcgus.com

Blair Kennedy

Consultant

bkennedy@pcgus.com





www.publicconsultinggroup.com