

# **State Health Reform Assistance Network**

## Charting the Road to Coverage

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# **Final 2017 Notice of Benefit and Payment Parameters and Letter to Federal Marketplace Issuers**

**Manatt Health**  
**March 10, 2016**

# Guidance Released by HHS on February 29, 2016



**Notice of Benefit and Payment Parameters for 2017 (Payment Notice):** Annual rulemaking in which HHS sets policies for Marketplaces and health insurance coverage



**2017 Letter to FFM Qualified Health Plan (QHP) Issuers:** Provides guidance for insurers in the Federally-facilitated Marketplace (FFM) as they develop plan offerings for 2017



**Rate Review Bulletin:** Issuers will need to submit rates as specified by the state, but no later than July 15



**Transitional Policy Bulletin:** Allows states to permit non-grandfathered coverage to delay full compliance for the entire 2017 calendar year

# Significant Regulatory Changes for 2017

## Standard Plan Designs

Voluntary standardized cost-sharing designs for bronze, silver, and gold plans, to minimize applicant confusion when shopping for QHPs on the FFM

## SBM-FP User Fee

In 2017, SBMs that use the federal platform (SBM-FP) will be required to make payments to HHS of 1.5% user fee (based on QHP premium)

## Network Adequacy

Time and distance standards deferred to give states time to act on NAIC model, new protections for continuity of care and out-of-network charges

## Rate Review

Changes to the rate review process for QHP issuers to increase transparency for all rate filings, not just large rate increases

## Risk Adjustment

Risk adjustment model changes to include the cost of preventive services and to reflect the trend in medical costs for particular services

## Eligibility & Enrollment

Changes to provisions pertaining to verifications (including income thresholds and employer sponsored coverage), renewals, and grace periods

# Voluntary Standardized Plan Design

Federally-facilitated Marketplace (FFM) will permit, *but not require*, FFM issuers to offer standardized metal level designs for 2017

## Rationale

- Allow applicants to focus on premium pricing, quality ratings, benefits, and provider networks

## Voluntary Program

- QHP issuers are not required to offer standardized plans and may offer non-standardized plans
- Standardized plans will get favorable placement and ranking treatment on HealthCare.gov (HHS is consumer testing specifics)

## State Law Implications

- Issuers in FFM states that have state law requiring particular cost sharing designs must comply with state law
- If the state law is different from the federal standardization options, issuer may be unable to offer standardized plans on the FFM

## Standardized Plan Design Features:



- Applies to bronze, silver, gold, and silver CSR variants

- Generic drugs and, in most cases, primary care not subject to deductible



- Silver and gold plans have no deductibles on prescription drugs or specialist visits

- Can have only one in-network provider tier



- Issuers may establish four or five cost-sharing tiers for prescription drugs

# State Based Marketplaces Using the Federal Platform (SBM-FP)

State Based Marketplaces that rely on HealthCare.gov, now called SBM-FP, will be assessed a 1.5% user fee in 2017

## Background

- SBMs in four states, Hawaii, Nevada, New Mexico, and Oregon have adopted HealthCare.gov as their platform for eligibility, enrollment, and financial management functions

## State Requirement

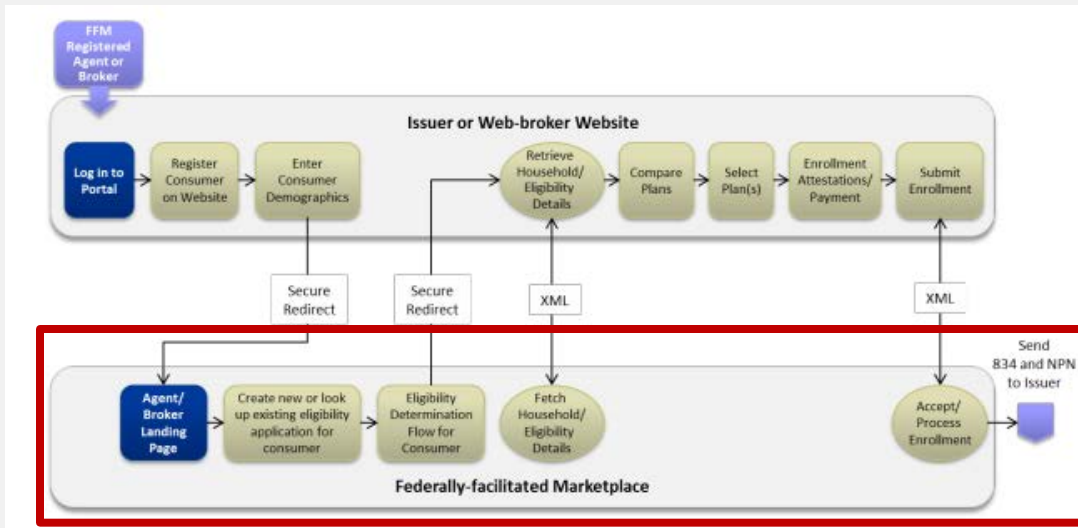
- States seeking to operate a new SBM-FP must submit a declaration letter in early 2016 and a blueprint in mid-2016
- State retains plan management, including authority for certifying QHPs
- State retains consumer assistance, including funding and training of Navigators

## Implementation

- States may choose to pay assessment directly to HHS or have HHS invoice issuer
- Issuers will be required to comply with FFM standards including transparency, casework, oversight, and meaningful difference requirements
- State could choose to implement for individual market, SHOP, or both

# Enhanced Direct Enrollment Process

## Current Direct Enrollment Process



## Current Process

- Marketplaces may permit applicants to enroll in QHPs via an issuer or broker website
- To be eligible for subsidies, eligibility must occur through Marketplace
- Currently, applicants are redirected from the website to the exchange and back for enrollment

## New Process

- For 2018, HHS intends to implement for the FFM a technology that would allow the applicant to be determined eligible without leaving the broker or issuer website and amend regulations to permit this pathway as an exchange enrollment



# Network Adequacy Standards

## Proposed

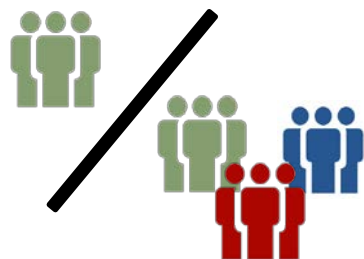
- In the draft notice, HHS proposed that the FFM establish county-specific time and distance standards for access to providers
- HHS would defer to state review if the state met certain standards

## Finalized

- HHS did not finalize proposal as commenters were concerned that the proposal did not give states the time and flexibility to develop their own standards under the 2015 NAIC model act (which does not require quantitative standards)
- HHS is continuing to enforce the “without unreasonable delay” standard in evaluating FFM plans
- Time and distance standards will be used to evaluate provider networks for the following categories:
  1. Hospital systems
  2. Dental providers
  3. Endocrinology
  4. Mental health
  5. Oncology
  6. Outpatient dialysis
  7. Primary care
  8. Rheumatology

# Network Strength Rankings

HealthCare.gov will rate each QHP's relative network strength calculated by the number of hospitals and providers



Issuers submit provider and facility data as part of 2017 certification process

CMS determines percentage of providers in a plan's network compared to the total number of available providers; known as the Provider Participation Rate (PPR)

Each plan's PPR is compared to the mean PPR for the county

**Broad:** Plan above one standard deviation of mean

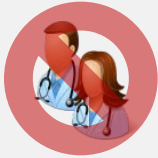
**Standard:** Plan within one standard deviation of mean

**Basic:** Plan below one standard deviation of mean

Comparison focuses on hospitals, adult primary care, and pediatric primary care

# Continuity of Care and Out-of-Network Enrollee Protections

## Plan Drops Provider



- FFM issuers are required to notify enrollees when a provider they regularly see is dropped from the network
- FFM issuers are required to continue to treat as in-network a provider who was dropped without cause, for up to 90 days



## Surprise Medical Bills



- If an enrollee receives care from an out-of-network ancillary provider the issuer is required to cover that service up to the annual limit on cost-sharing unless the issuer provided advance notice
- Does not prohibit balance billing and does not apply to QHPs without any out-of-network benefits

# Premium Rate Transparency

HHS is requiring that all issuers submit uniform rate review templates for all products, including those that do not have a rate increase

## Justification

- HHS is collecting rate filings for all single risk pool products to fulfil ACA requirements that the Secretary monitor premium increases of health insurance coverage
- HHS will post rate filings at a uniform time to promote competition between insurers
- States with effective rate review programs continue to be required to post proposed rate increases for public comment
- States may withhold information which is considered trade secret or confidential

# Premium Rate Review Timeline

## May 11, 2016

Issuers in states without effective rate review must submit rate filings (or earlier depending on state law)

## August 1, 2016

States with an effective rate review program must publically post proposed rate increases

May 2016

July 2016

August 2016

November 2016

## July 15, 2016

Issuers in states with effective rate review must submit rate filings (or earlier depending on state law)

## August 23, 2016

Deadline for reviewing and finalizing rate filings that contain QHPs seeking to participate in Marketplaces served by HealthCare.gov

## November 1, 2016

Open enrollment begins, deadline for all final rate data (including those not subject to review)

Target date to post public use file with final rate data

# Risk Adjustment Model Changes

## 2017 Changes

### **To improve accuracy of risk adjustment for 2017 HHS is:**

- Including cost of preventive services
- Trending coefficients to reflect changes in medical costs since 2014

## Future Changes

### **In a forum on March 31, 2016 and an associated white paper to be released this month, HHS will address potential changes for future years including:**

- Enrollee socioeconomic status as an input
- Use of prescription drug claims as an input
- Impact of partial year enrollees
- Change data-collection approach to make individual claims available to calibrate model for future years

# Benefit Design Issues

## Conflict Between Formulary Exception and Coverage Determination Appeals

### 2016 Payment Notice

Created potential conflict between state coverage determination appeals law and new external review process for formulary exception requests

### 2017 Payment Notice

State process can prevail as long as it provides external review of formulary exception requests and exception requests decided within 72 hours (24 hours for urgent)

## Expanded Formulary Access Reviews

Formularies will be reviewed for coverage and tiering of clinically appropriate drugs for bipolar disorder, breast cancer, diabetes, hepatitis C, HIV, multiple sclerosis, prostate cancer, rheumatoid arthritis, and schizophrenia

## Discriminatory Benefit Design

HHS cautions that the fact that a benefit design is similar to other benefit designs offered in the market does not make it non-discriminatory

# State Essential Health Benefit Mandates

State mandated benefits enacted after 2011 generally do not count as Essential Health Benefits (EHB)

## Background

- ACA establishes an EHB package to be covered by plans in the individual and small group markets
- States are required to cover the cost of benefit mandates in excess of EHB
- The EHB package is defined by a state-specific benchmark plan
- For 2017, the EHB package will be defined by plans offered in 2014

## Clarification

- Even if a post 2011 state benefit mandate was applicable to 2014 plans it will generally not count as EHB
- States will be required to cover the cost of such state benefit mandates
- The state (likely Department of Insurance) is the entity that identifies which mandated benefits are EHB



# New Requirements on Navigators



**Post-Eligibility Navigator Responsibilities:** The final rule requires Navigators in the FFM to assist consumers with the following post-enrollment activities:

- **Understanding eligibility appeals:** Navigators may not represent the consumer in the appeal but can provide information on the process
- **Filing exemptions:** Navigators may assist consumers in understanding the exemptions available to them and the process for obtaining those exemptions
- **Providing information on reconciliation of the tax credit:** Navigators may not offer tax assistance or interpret tax rules but are required to help consumers understand the tax credit reconciliation process
- **Understanding how to use insurance:** Navigators are required to help consumers understand basic insurance concepts and may be supported by existing resources such as the HHS “From Coverage to Care” initiative



# Third Party Payments



Issuers are generally encouraged to reject third-party payments for premium and cost-sharing from healthcare providers

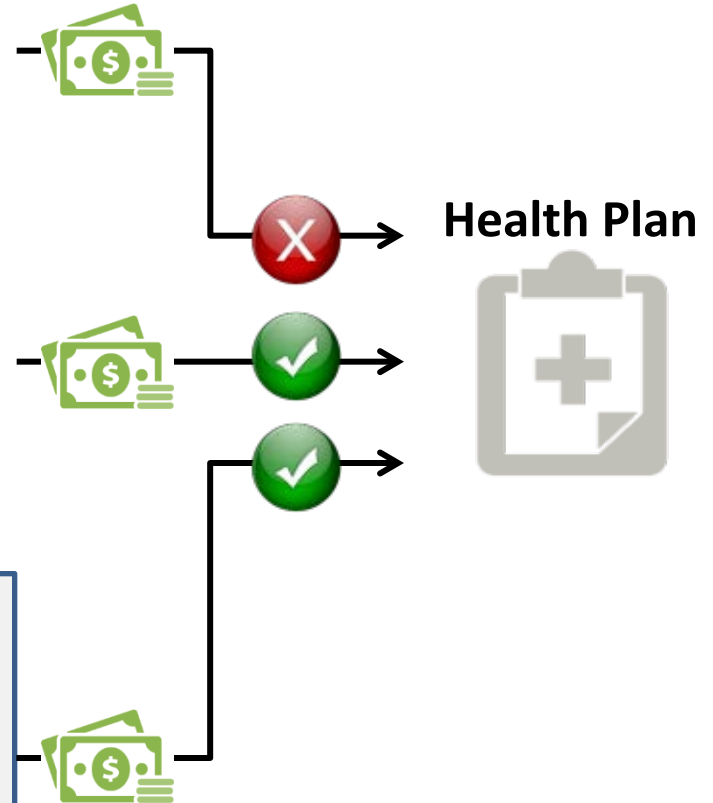


Issuers required to accept third-party payments from Ryan White HIV/AIDS Program and other federal, state, and tribal government programs



## **New Requirements:**

Issuers now must accept third party payments from local governments. HHS is also specifying that payments must be accepted directly from both government agencies and grantees



# Eligibility and Enrollment Related Provisions

## Verifications:

- HHS is allowing Marketplaces flexibility to set a “reasonable threshold” for when alternate data sources may be used to verify income
- In 2018, Exchanges will no longer be required to select a random sample and contact employers to verify offers of employer sponsored coverage

## Renewals:

- If during renewal an enrollee’s current silver QHP is not available, the enrollee will automatically be enrolled in another similar silver plan offered by the issuer
- If the issuer is no longer offering Marketplace coverage, Marketplace must try to enroll consumer in a QHP of a different issuer at same metal level



## Non-Payment Grace Periods:

- Existing regulations require a three month grace period before coverage is terminated after an enrollee receiving subsidies stops paying premiums
- HHS is expanding this grace period to include consumers who lose eligibility for subsidies and those whose grace period spans a new year

## Small Business Health Options Program

- Small employers will have a new option to choose a single issuer and allow employees to choose any plans offered by that issuer (vertical choice)
- States with a SHOP running on HealthCare.gov may opt out of vertical choice if they believe it would lead to adverse selection

# Discussion



# Thank you!

Heather Howard [heatherh@princeton.edu](mailto:heatherh@princeton.edu)

Brian Shott [bshott@princeton.edu](mailto:bshott@princeton.edu)

Joel Ario Jario [Jario@Manatt.com](mailto:Jario@Manatt.com)

Deborah Bachrach [DBachrach@Manatt.com](mailto:DBachrach@Manatt.com)

Patti Boozang [PBoozang@Manatt.com](mailto:PBoozang@Manatt.com)

Michael Kolber [Mkolber@Manatt.com](mailto:Mkolber@Manatt.com)

Spencer Manasse [SManasse@Manatt.com](mailto:SManasse@Manatt.com)