

Final HHS Notice of Benefit and Payment Parameters for 2016

The final HHS Notice of Benefit and Payment Parameters released today establishes key standards for issuers and Marketplaces for 2016. It includes payment parameters applicable to the 2016 benefit year, and proposes new standards to improve consumers' experience and ensure coverage is affordable and accessible. Today's final rule generally addresses coverage that will be available to consumers in 2016.

Key policies in today's final rule include:

Market Rules

Bringing Transparency and Fairness to Health Insurance Rate Increases: Issuers seeking rate increases of 10 percent or more (or above a state-specific threshold) for non-grandfathered coverage in the individual or small group market are required to publicly disclose the proposed increases and the justification for them, and the increases are reviewed by state or federal regulators to determine whether they are unreasonable. We finalize a change to the trigger for review, such that, beginning with rates filed in 2016 for coverage effective on or after January 1, 2017, rate increases will be subject to review when any plan within a product has an increase that meets or exceeds the applicable threshold. We also finalize an approach to ensure that there is a uniform timeline for issuers to submit rate filings and states with effective rate review programs to provide public access to rate information about QHPs and non-QHPs in the individual and small group markets. States with effective rate review programs have flexibility to establish earlier timeframes to meet their specific state needs.

Eligibility, Enrollment, and Benefits

Annual Open Enrollment Period: We have set the open enrollment period for non-grandfathered policies in the individual market, inside and outside the Marketplace, for the 2016 benefit year to run from November 1, 2015 through January 31, 2016.

Hardship Exemptions: Consistent with prior guidance, we 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 permit individuals who are eligible for services from an Indian health care provider to claim a hardship exemption through the tax filing process.

Habilitative Services: We define habilitative services and devices using the same definition of habilitative services from the Uniform Glossary of Health Coverage and Medical Terms, effective for plan years beginning in 2016, and require issuers to have separate visit limits on habilitative and rehabilitative services starting with the 2017 plan year.

Revised Essential Health Benefits Benchmark Selection: We provide that states may select new benchmark plans for 2017, based on plans available in 2014.

Pediatric Age: We modified our proposal and finalize a requirement that pediatric benefits be provided until the end of the month in which the enrollee turns 19, which aligns with current industry practice.

Prescription Drug Coverage: Our current drug coverage policy is based on issuers including in their formulary drug lists the greater of one drug for each U.S. Pharmacopeia (USP) category and class or the same number of drugs in each USP category and class as the state's EHB benchmark plan. Under our

final rule, issuers must also use a pharmacy and therapeutic (P&T) committee system, which will design formularies using scientific evidence that will include consideration of safety and efficacy, cover a range of drugs in a broad distribution of therapeutic categories and classes, and provide access to drugs that are included in broadly accepted treatment guidelines. In contrast to our proposal, issuers will use the P&T committee process, starting in 2017, and must also satisfy the current USP drug count standard.

Formulary Drug List: We clarified that a health plan must publish an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure and any restrictions on the manner in which a drug can be obtained, in a manner that is easily accessible to plan enrollees, prospective enrollees, the state, the Marketplace, HHS, OPM, and the general public. Additionally, issuers must also make this information available in a standard machine readable format to provide the opportunity for third parties to create resources that aggregate information on different plans.

Drug Exceptions Process: Our current regulations require that issuers have processes through which an enrollee can request and gain access to a drug not on the formulary. In the final rule, we established more detailed procedures for the standard review process, and a requirement that issuers have a process in place under which an enrollee can request an independent external review if the health plan denies an initial request made on a standard or expedited basis. We also clarified that cost sharing for drugs obtained through the exceptions process must count toward the annual limitation on cost sharing for health plans subject to the EHB requirement.

Drug Mail Order Opt Out: We finalized provisions that require issuers to provide most drugs at network retail pharmacies, instead of only through mail order. Issuers will be allowed to charge different cost sharing if the enrollee obtains the prescription drug at a retail location.

Benefits Discrimination: Existing rules provide that “an issuer does not provide essential health benefits if its benefit design, or the implementation of its benefit design, discriminates based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.” We remind issuers of specific practices may be considered discriminatory, including restricting services based on age when the service may be appropriate for all ages, and placing most or all drugs for a specific condition on a high cost-sharing tier. Our intention is to make plans aware of impermissible benefit designs. We review for these practices when we certify QHPs, and encourage states to do the same.

Determination of Minimum Value: Consistent with recently published guidance, we provide that, in order to meet minimum value standards, a plan must provide a benefit package that reflects benefits historically provided under “major medical” employer coverage. Specifically, to satisfy the minimum value requirement, coverage must include substantial coverage of both inpatient hospital services and physician services.

Transparency in Coverage: We remind QHP issuers that because a full year of claims data will be available, we will require that they make certain information available to HHS starting in 2016. We will issue guidance on this information soon.

Meaningful Access Standards: We specify that, for Marketplaces, QHP issuers, and web-brokers, their existing general requirement to provide “oral interpretation” services must include providing telephonic interpreter services in at least 150 languages. The FFM call center is already meeting this standard. Marketplaces, QHP issuers, and web-brokers must provide taglines on websites and critical documents in 15 languages and Marketplaces and web-brokers must translate content to any language spoken by at least 10% of the state’s population in 2017. New web-brokers will have additional lead time to meet this standard.

Network Adequacy (Provider Directories): We clarify that a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, in a manner that is easily accessible to plan enrollees, prospective enrollees, the state, the Marketplace, HHS, and OPM. As part of this requirement, we finalize that a provider directory is considered to be easily accessible when the general public is able to view all of the current providers for a plan in a provider directory on the plan's public website through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number. Additionally, issuers must also make this information available in a standard machine readable format to provide the opportunity for third parties to create resources that aggregate information on different plans.

Essential Community Providers: We codify the standard for QHP issuers used in 2015 for the FFM – that issuers seeking qualified health plan certification in the FFM subject to the general essential community provider standard will be required to offer provider contracts to: (a) all available Indian health providers in the service area; and (b) at least one essential community provider in each essential community provider category (i.e., Federally Qualified Health Clinics, Ryan White providers, family planning providers, hospitals, and others) in each county in the service area, where a provider in that category is available. We also codified and updated the 2015 FFM policy that provides a percentage threshold for 2016 through HHS guidance, informed by our assessments of the adequacy of essential community provider participation and geographic distribution of such providers.

Improving Consumer Access to Information: QHP issuers must provide consumers in all Marketplaces with a summary of benefits and coverage (SBC) for each plan variation of a standard QHP at the times required under the SBC regulations, so that consumers have greater access to plan information with cost-sharing reductions taken into account.

Quality Improvement Strategy (QIS): To obtain QHP certification, each issuer must implement a QIS, which is a payment structure that provides increased reimbursement or other incentives to improve health outcomes, reduce hospital readmissions, improve patient safety and reduce medical errors, implement wellness and health promotion activities, and reduce health and health care disparities. A QHP issuer participating in a Marketplace for at least two years is required to implement and report information regarding a QIS. We direct such QHP issuers to submit data annually for activities that are conducted in relation to implementation of its QIS.

Strengthening the MLR Program: Consistent with the practice of the majority of issuers, the final rule clarifies that that Federal and State employment taxes should not be excluded from premium in the MLR and rebate calculations. We also provide that subscribers of non-federal governmental or other group health plans not subject to ERISA must receive the benefit of MLR rebates within three (3) months of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do.

SHOP: This final rule includes provisions to streamline the administration of the SHOP:

- The rule would permit SHOPS to assist employers in the administration of continuation coverage (COBRA) enrolled in through a SHOP.
- Based on input from stakeholders, we permit a SHOP to elect to renew an employer's offer of coverage where the employer remains eligible to participate in the SHOP, and has taken no action to modify its offer of coverage or withdraw from the SHOP during its annual election period, so long as the offered coverage remains available through the SHOP.
- We modified the calculation of minimum participation rates in the SHOP to align with the current practice of issuers in many states and to include other types of coverage in the calculation of the group's rate. We are limiting this policy to the FF-SHOP, effective for plan years beginning on or

after January 1, 2016, and letting states decide how to calculate minimum participation rates for state SHOPs and the non-SHOP small group market.

- We aligned SHOP QHP certification in SHOPs that certify QHPs on a calendar year basis with rolling enrollment in the SHOP, thus ensuring that employers can start coverage through the SHOP at the beginning of any month with coverage through the SHOP lasting for 12 months.
- We finalized an exception to the rule regarding 12-month plan years in the SHOP for states with merged individual and small group risk pools under federal law.
- We specified that a qualified employer that fails to pay its premium for FF-SHOP coverage in a timely manner can be reinstated in its prior coverage only once per calendar year.
- Finally, we specify that, effective January 1, 2016, certain termination notices will be provided by the SHOP.

Payment Parameters

Promoting Stable Individual Market Premiums: In this final rule, we reduce the 2015 attachment point from \$70,000 to \$45,000. Given the smaller reinsurance payments pool for 2016, for the 2016 benefit year, we are raising the attachment point to \$90,000, holding the reinsurance cap at \$250,000, and maintaining the coinsurance rate of 50 percent. Additionally, we are finalizing a 2016 reinsurance contribution rate to be paid by health insurance issuers and certain self-insured group health plans of \$27 annually, per enrollee.

2016 User Fees: HHS collects a user fee from participating issuers to fund federally-facilitated Marketplace operations. For 2014 and 2015, the user fee rate was set at 3.5 percent of the monthly premium charged by the issuer. Based on enrollment and premium projections, we estimate that to cover total costs, the 2016 user fee rate will also be set at 3.5 percent of the monthly premium charged by the issuer.

Premium Adjustment Percentage Index: The premium adjustment percentage is the percentage by which the average per capita premium for health insurance coverage in the United States exceeds the average per capita premium for 2013. We finalize a premium adjustment percentage for the two-year period of 8.3 percent. This includes both the estimated 4.3 percent premium increase between 2013 and 2014, as well as a further 3.9 percent estimated premium increase between 2014 and 2015. Based on this we finalize a 2016 maximum annual limitation on cost sharing of \$6,850 for self-only coverage, \$13,700 for other than self-only coverage, and an 8.1 percent required contribution percentage for 2016 under Section 5000A of the Internal Revenue Code.

Reduced Maximum Annual Limitation on Cost Sharing: For individuals with household incomes of between 100-200 percent of the Federal Poverty Level (FPL), we finalize a 2016 reduced maximum annual limitation on cost sharing for self-only coverage of \$2,250. For individuals with incomes between 200-250 percent FPL, we finalize a reduced maximum annual limitation on cost sharing for self-only coverage of \$5,450.

Other Provisions

Risk Adjustment Model Recalibration: Risk adjustment factors that reflect enrollee health risk are developed using claims data and reflect the relative costs of a given disease to average spending. We are updating the 2016 benefit year risk adjustment factors using multiple years of data.

Defining Common Ownership or Control: Self-insured plans that do not use a TPA do not make reinsurance contributions in the 2015 and 2016 benefit years. We consider a TPA to be an entity that is

not under common ownership with the self-insured group health plan or its sponsor that provides administrative functions in connection with the core administrative services noted above. In response to stakeholder questions, we clarify that common ownership should be determined according to section 414(b) and (c) of the Internal Revenue Code.

Self-insured Expatriate Plans: Insured expatriate plans do not make reinsurance contributions. In this final rule, we provide that self-insured expatriate plans are also not required to make reinsurance contributions for the 2015 and 2016 benefit years. In conjunction with the Departments of Labor and Treasury we will undertake future rulemaking consistent with new federal legislation on expatriate plans. We do not anticipate that this future rulemaking will affect the availability of the exemption for the expatriate plans in this final rule.

Clarification on Risk Corridors: We reiterate our current policy that the risk corridors transitional adjustment for benefit year 2014 does not encompass early renewal plans (plans that renewed before January 1, 2014, and before the end of their 12-month term) unless and until the plan renews in 2014 and becomes a transitional plan.

Allocation of Risk Corridors Collections for 2016: If, in the last year of the risk corridors program, we have excess cumulative risk corridors collections that exceed the cumulative risk corridors payments owed (that is, collections received over the course of the 3-year program exceed total payments requested over the 3 years), we will implement an adjustment to the profit floor and administrative cost ceiling to increase risk corridors payments for eligible issuers for benefit year 2016. We reiterate our previous guidance that in the unlikely event that risk corridors collections, including any potential carryover from prior years, are insufficient to make risk corridors payments for the 2016 program year, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations.

Non-Navigator Organizations: Physical Presence Requirement: We specify that the requirement to maintain a physical presence in a Marketplace service area applies to a non-Navigator entity as a whole, not each individual working for the entity.

Standards for HHS-Approved Vendors of FFM Training for Agents and Brokers: We finalize a process under which HHS may recognize the successful completion of a Marketplace training program from an approved vendor as sufficient to satisfy the requirement to receive training in the range of QHP options and the insurance affordability programs. Under the final rule, HHS has the authority to approve and oversee vendors that provide training to agents and brokers in the FFMs, as well as perform information verification functions such as identity proofing. We provide that to become an HHS-approved vendor, the organization must demonstrate that it meets specified criteria pursuant to an application process established by HHS.

Good Faith Compliance Extension through 2015: We are finalizing the proposal to extend the good faith compliance policy for QHP issuers participating in the FFMs, as well as for HHS-operated risk adjustment and reinsurance data requirements, that was adopted for the 2014 calendar year through the 2015 calendar year.