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2016 NOTICE OF BENEFIT AND PAYMENT PARAMETERS

DRAFT NOTICE

On November 26, 2014 HHS published its Draft Notice of Benefit and Payment Parameters for 2016.[1] The notice contains rules and parameters that would apply to the individual and small group health insurance markets in 2016, and modifications to previously promulgated rules. This document represents a summary of our interpretation of the draft notice and does not constitute, nor is it a substitute for, legal advice.

1 Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Proposed Rule," November 26, 2014 http://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27858.pdf

MARSH & McLENNAN COMPANIES

HEALTH INSURANCE MARKET REFORM REQUIREMENTS

1. Requirements Relating to Health Insurance Coverage (pp. 30-33 of the Draft Notice)
   - **Plan:** A plan is defined as the pairing of the covered benefits under the product with a particular cost-sharing structure, provider network, and service area, even if the plans are in the same metal level. Comments are sought on how to determine whether changes to these characteristics constitute uniform modifications of coverage upon renewal.
   - **State:** The proposed rule would codify the provisions of the July 16, 2014 letter issued to the US Territories which stated that the term "State" does not include the territories for purposes of Part 147. Therefore, the following provisions do not apply to the territories: guaranteed availability, community rating, single risk pool, rate review, medical loss ratio, and essential health benefits.

2. Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets (pp. 33-39 of the Draft Notice)
   - Guaranteed Availability of Coverage
     - The proposed rule extends the availability of the special enrollment period for a person who, in any year, has coverage on a non-calendar year basis
     - Individuals have 60 days before and after the event triggering a special enrollment period to select a plan, whether the plan is purchased inside or outside the individual Exchange
   - Guaranteed Renewability of Coverage
     - Issuers may discontinue a product if the issuer offers to enroll those affected in any other coverage offered by the issuer
       - The Notice clarifies that issuers may not satisfy this requirement by auto-renewing those enrollees in a plan offered by a separately licensed entity
       - Issuers may offer plans of a separately licensed entity in the case of market withdrawal by the issuer
       - Comment is sought on how to apply guaranteed renewability provisions in the case of mergers, acquisitions, and other changes in corporate structure
     - For mid-year corporate structure changes, issuers would be required to continue administrative processes under the original HIOS identifying information until the coverage year is complete
       - A notification of such changes to policyholders is being proposed

STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT

1. Provisions for the State Notice of Benefit and Payment Parameters (pp. 39-40 of the Draft Notice)
   - The deadline for publishing a State notice of benefit and payment parameters would change from March 1st of the calendar year prior to the applicable benefit year to the later of March 1st of the calendar year prior to the applicable benefit year or the 30th day following the publication of the final HHS notice of benefit and payment parameters for that benefit year

2. Provisions and Parameters for the Permanent Risk Adjustment Program (pp. 40-73 of the Draft Notice)
   - The 2016 risk adjustment fee is proposed to increase to $1.75 per enrollee per year, from $0.96
   - The risk adjustment methodology and the payment transfer formula would not change for 2016
     - HHS is proposing to assign infants without birth hierarchical condition categories (HCCs) to "Age 1" by severity level
     - The risk adjustment methodology would continue to include an adjustment for individuals enrolled in cost sharing reduction (CSR) plans
     - The risk adjustment methodology would continue to not adjust for receipts from the Transitional Reinsurance Program (TRP)
   - HHS is proposing to recalibrate the risk adjustment model for 2016 to use more recently available data
     - Risk factors would be updated using 2010, 2011, and 2012 MarketScan data; however, if 2013 MarketScan data is available prior to the publication of the final rule, risk factors would be updated using the three most recently available years of MarketScan data
       - HHS is considering two approaches to developing the risk factors for HCCs:
         i. Pooling data across the three years of sample data
         ii. Developing coefficients for each year of data and blending the three independently calibrated coefficients together (HHS is leaning towards this approach for transparency)
       - A comparison of the risk factors from the proposed risk adjustment model versus the current risk adjustment model shows:
         i. The demographic risk factors for adults and children have been lowered slightly relative to the current risk adjustment model
         ii. The diagnosis risk factors experienced some changes with the greatest changes occurring for HCCs with higher risk factors, particularly for children (e.g., lung transplant status/complications for children changing from a risk factor of 100.413 to 33.090)
     - HHS is seeking comment on whether to implement the proposed risk factors retroactively for 2015
   - A technical modification is being proposed to the transfer formula for community rated states that utilize family tiering factors
     - The formula previously did not distinguish between billable member months and subscriber months

3. Provisions and Parameters for the Transitional Reinsurance Program (pp. 73-92 of the Draft Notice)
   - The definition of contributing entity for the purposes of paying the fee for the TRP excludes self-funded groups that are also self-administered (i.e., the TPA paying claims is under the control or common ownership of the self-funded group)

  - The Notice clarifies what it means to be under control or common ownership by making reference to the Internal Revenue Code
- Under current regulation, only insured expatriate plans are exempt from making reinsurance contributions
  - The Notice extends the exemption to self-insured expatriate plans, starting with the 2015 benefit year
- As is the case with counting for the contribution to the Patient-Centered Outcomes Research Trust Fund, health insurance issuers would be required to use the same counting method for all members covered by both self-funded and fully insured major medical plans to calculate annual enrollment for the purposes of the reinsurance contribution in a state for a benefit year
  - Issuers would be allowed to use different methods in different states
  - If finalized, this proposal would apply to both 2015 and 2016 benefit years, but different counting methods could be used in different benefit years
  - This requirement would not apply to self-funded groups, as they may have business administered by more than one issuer
- Contributing entities that use either the snapshot count method or the snapshot factor method would be allowed to adjust their counts to account for mid-quarter changes to the plan (e.g., switching from fully insured to self-funded)
  - The set of counting dates used would be required to only include dates on which the plan has enrollees
  - For those quarters where coverage was only in effect for part of the quarter, the enrollment count can be reduced by a factor to reflect a reduction for the months during which coverage was not in effect
- HHS estimates that it would need $32 MM for administering the reinsurance program and so would need to collect $5.032 BN to fund the $4 BN for reinsurance payments, the $1 BN that would go to the US Treasury, and the $32 MM for administration
  - Dividing this by the estimated number of enrollees in plans required to make reinsurance contributions yields a contribution of $27 per member per year for the 2016 benefit year
- As was the case with 2014 and 2105, in 2016 HHS proposes to use all funds collected to first fund the reinsurance payment pool, up to $4 BN, then any remaining funds would be allocated pro-rata to administration and the Treasury
  - If excess funds are collected, the excess would be paid out by increasing the coinsurance rate up to 100% before rolling over any remaining funds to the 2017 benefit year
- Reflecting the reduced funding for the TRP, the 2016 payment parameters would be a $90,000 attachment point, a $250,000 reinsurance cap, and 50% coinsurance
  - HHS estimates that these parameters would result in the full $4 BN being paid for 2016 claims
- Consistent with HHS's intent announced in the 2015 Market Standard Rules, HHS is planning to reduce the 2015 attachment point from the $70,000 that was announced in the 2015 Notice, to $45,000
- The treatment of reinsurance for individuals enrolled in CSR plans would be altered
  - In the 2015 Notice, HHS said it would deduct from the paid amounts the difference between the annual limit on cost sharing for the standard plan and the last plan variation covering the member
  - In the 2016 Notice, HHS has proposed changing this so that they would deduct from the paid amounts the difference between the annual limit on cost sharing for the standard plan, and an average of the annual limit on cost sharing for the covered member for the plan variations, weighted by member months
    - This change would not apply for an Indian in a limited CSR variation

4. Provisions for the Temporary Risk Corridors Program (pp. 92-97 of the Draft Notice)
   - Recognizing the effects of the transitional policy allowing for the renewal of non-ACA complaint policies through October 1, 2016, HHS would vary the adjustment to the risk corridor parameters, increasing the profit margin floor and the allowable administrative cost ceiling, to help offset losses that could result from the transitional policy
     - HHS would vary the adjustment with the percentage of enrollment in transitional plans in the State
     - The adjustment would exclude early renewals as issuers could reasonably have anticipated early renewals in their 2014 pricing
   - For 2016, if cumulative risk corridor collections (from 2014 through 2016) exceed both 2016 payment requests and any unpaid risk corridor amounts from previous years, the administrative cost ceiling and the profit floor would both be adjusted by the same percentage in such a way as to pay out all collections
     - The excess payments would only be made to issuers that had allowable costs of at least 80% of after-tax premiums
     - These excess payments would not be considered in the medical loss ratio (MLR) calculation
   - In the Notice, HHS reiterates its position that if risk corridor collections are not sufficient to make risk corridor payments, HHS would use other sources of funding, subject to the availability of appropriations

5. Distributed Data Collection for the HHS-Operated Risk Adjustment and Reinsurance Programs (pp. 97-100 of the Draft Notice)
   - As is the case with 2014, in 2015, issuers would not be subject to civil money penalties for non-compliance with the HHS-operated risk adjustment and reinsurance data requirements, provided the issuer has made good faith efforts to comply
     - The default risk adjustment charge would still apply
     - The safe harbor would not apply in 2016, even if the non-compliance relates to the 2015 benefit year
   - If an issuer did not comply with HHS's data requirements, HHS would assess a default risk charge
     - HHS would allocate these default risk charge funds among risk adjustment covered issuers in proportion to an issuer's enrollment, adjusted for factors such as health risk, actuarial value and geographic cost differences

HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS

1. General Provisions (pp. 101-102 of the Draft Notice)

- The amendments in this section of the Notice would apply beginning with rates filed during the 2015 calendar year for coverage effective on or after January 1, 2016, unless otherwise noted
- Proposed changes to definitions that may be impactful are as follows:
  - The definition of "plan" is added and reflects the term in §144.103
  - The definition of "rate increase" is revised to include an increase of rates for a plan as opposed to the product level when determining whether a rate increase is subject to review
  - The definition of "State" is revised to exclude the US territories of Puerto Rico, the Virgin Islands, Guam, American Samoa and the Northern Mariana Islands

2. Disclosure and Review Provisions (pp. 102-108 of the Draft Notice)

- The standard for determining whether a rate increase is subject to review would be modified to reflect rate increases at the plan level as opposed to the product level
  - If an increase in the plan-adjusted index rate for any plan within a product meets or exceeds the applicable threshold, all plans within the product would be subject to review in determining whether the rate increase is unreasonable
  - A Rate Filing Justification would be required for all rate filings that propose a rate increase for any plan within a product in the individual or small group market
  - This clarification becomes effective with the effective date of the final rule
- HHS is proposing to establish a uniform timeline for the submission of the Rate Filing Justification
  - All rate increases in every relevant State market (i.e., individual, small group, or merged) for both qualified health plans (QHPs) and non-QHPs would be required to be filed by a consistent time each year; the timeline is the earlier of the following:
    - The date by which the State requires that a proposed increase be filed with the State, or
    - The date specified by the Secretary in guidance (HHS is proposing this to coincide with the end of the QHP application window for the FFE)
- The Notice proposes changes to rate increase disclosure requirements for States with Effective Rate Review Programs
  - The State would be required to provide access from its website to at least information contained in Parts I, II and III of the Rate Filing Justification that CMS makes available on its website within 10 business days after receipt of all rate filings, and a mechanism for receiving public comments
  - The State would be required to provide this information for all final increases by no later than the first day of open enrollment
    - This information would be required to be provided for both rate increases that meet or exceed the review threshold and those not subject to review
  - The State would be required to ensure the information it posts on its website for the public is made available at a uniform time without regard to whether the plans are offered on or off the Exchange

EXCHANGE ESTABLISHMENT STANDARDS

1. General Provisions (pp. 108-111 of the Draft Notice)
   - The definition of "applicant," "enrollee," and "qualified employee" may be expanded to include former employees
     - Former employees would include retirees as well as former employees to whom an employer might be obligated to provide continuation coverage
     - A qualified employer would be required to have at least one current working employee who enrolls in order for the coverage to be issued through the SHOP to a former employee
   - A possible amendment to the definition of "enrollee" may be introduced to include dependents of qualified employees
   - These potential definition changes would allow qualified employers to offer coverage through a SHOP to its former employees as well as dependents of current and former employees

2. General Functions of an Exchange (pp. 111-120 of the Draft Notice)
   - To provide a specific standard to every Exchange consumer, a requirement to make oral interpretation services and all information that is critical for obtaining health insurance coverage (e.g., applications, forms) available in at least 150 languages is being proposed
     - This standard would be specifically for Exchanges, web-brokers, and QHP issuers
     - This may not apply to Navigators and non-Navigator assistance personnel
     - Other potential language accessibility standards are being considered
   - Only non-Navigator assistance *entities* would be required to maintain a physical presence in the Exchange service area
     - This allows individuals providing non-Navigator assistance to provide it remotely (except when the individual is not affiliated with a larger entity and is therefore considered to be the entity)
   - The Notice proposes an additional avenue for agents and brokers to complete training requirements necessary to work with FFE consumers
     - The goal is to make the training and registration process easier, and attract greater agent and broker participation in the FFEs
     - Under this proposal, certain training and information verification functions could also be provided through HHS-approved vendors; previously, training was only provided by HHS
     - Organizations interested in becoming HHS-approved vendors would be required to demonstrate that they meet established standards
     - HHS would determine whether each organization is approved on an annual basis

3. Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs (pp. 120-122 of the Draft Notice)
   - HHS is exploring implementing a re-enrollment hierarchy for the FFEs where an insured could opt into being re-enrolled by default into a lower cost plan rather than his or her current plan
     - The enrollee at the time of initial enrollment would choose their re-enrollment hierarchy
     - This alternate enrollment hierarchy could be triggered if the enrollee's current plan's premium increases from the prior year, increases by more than premiums of similar plans, or increases by more than a threshold amount such as five percent or 10 percent

- The re-enrollment hierarchy is being proposed for the 2017 coverage year
  - Based on this timeline, consumers could select a hierarchy during their open enrollment in 2015 for the 2016 coverage year

4. Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans (pp. 122-134 of the Draft Notice)

- HHS is proposing to establish a standard policy regarding the deadline for payment of the first month's premium for enrollees in QHPs
  - This has traditionally been a business decision made by issuer, but HHS believes that a uniform deadline would ensure a consistent operational procedure that would benefit the issuer and the insured
  - The deadline would not be in effect during the open enrollment for 2015 coverage
- HHS is proposing the annual open enrollment for benefits years 2016 and later to begin on October 1st and end on December 15th of the calendar year preceding the benefit year
  - All coverage would be effective on January 1st of the year following the open enrollment period
- The Notice maintains the requirement to allow the effective date to be the date of birth, adoption, placement for adoption, or placement in foster care for these specific qualifying events, but also proposes to allow a qualified individual to elect a regular coverage effective date as applicable to any other qualified individual or enrollee
  - This would remove the current option to choose the first of the month following the birth, adoption, placement for adoption or placement in foster care as the effective date
- The Notice includes several other proposed changes or clarifications related to qualifying events
  - Consumers making a permanent move would be allowed to apply for their special enrollment period prior to their permanent move which would reduce potential gaps in coverage
  - An Exchange would be required to make coverage effective the first day a court order, such as a child support order, is effective; a choice of a regular effective date could also be offered
  - Issuers would be required to allow any qualified individual that has a renewal outside of the annual open enrollment period to qualify for a special enrollment
    - This would allow individuals with a group health plan, grandfathered individual market plan, or transitional individual market plan an alternative option for coverage without having to wait until open enrollment for the individual market
  - Enrollees who lose a dependent or lose dependent status through legal separation, divorce, or death would be provided a special enrollment period
    - Currently, depending on the circumstances surrounding the divorce, legal separation, or death, the applicant may be determined eligible for a special enrollment period
  - HHS is considering allowing a special enrollment period due to any errors caused by a non-Exchange entity providing enrollment assistance
  - A qualified individual in a non-Medicaid expansion state who was previously ineligible for advance payments of the premium tax credit due to a household income below 100 percent FPL and was also ineligible for Medicaid during that same timeframe would be provided a special enrollment period if they experience a change in household income that makes the individual newly eligible for advance payments of the premium tax credit
- HHS is considering allowing greater flexibility around retroactive termination effective dates when an enrollee initiates the termination, if specified by applicable state laws such as "free look" provisions
  - The Exchange would continue to ensure that appropriate actions are taken to make necessary adjustments to advance payments of the premium tax credit, cost-sharing reductions, Exchange user fees, premiums, and claims, while adhering to any state law

  - Exercising a "free look" period would not entitle the enrollee to a special enrollment period
- Guaranteed availability is interpreted to mean that a QHP offered through the Exchange generally would be required to be available outside the Exchange
- Guaranteed renewability is interpreted to mean that a QHP offered through the Exchange would be required to be renewable outside the Exchange

5. Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions (pp. 135-138 of the Draft Notice)
   - HHS proposes an amendment to provide a hardship exemption to an individual who is not a dependent of another taxpayer and whose gross income is less than the individual's minimum threshold for filing a Federal income tax return
     - The IRS and Department of the Treasury are expected to publish guidance on how to claim this exemption without anticipating a certificate number from the Exchange
     - It is anticipated the individual would not be required to file a Federal income tax return in order to claim the exemption
   - A proposal is being considered to change the definition of Indian so that it would cross-reference with the Medicaid definition
   - A change is being considered that would allow individuals who are eligible for services through an Indian Health Service, a Tribal health facility, or an Urban Indian organization the same shared responsibility exemption process available to Federally-recognized tribal members
   - The required contribution percentage, calculated as the required amount to pay for minimum essential coverage (MEC) divided by the actual household income for a taxable year, which determines whether an individual qualifies for a hardship exemption is expected to be 8.13% for 2016
     - In 2014, the required contribution percentage is 8%; in 2015 it is 8.05%
     - This number has grown due to the average growth of premiums being higher than the average growth of income

6. Exchange Functions: Small Business Health Options Program (pp. 138-152 of the Draft Notice)
   - The SHOP is able to assist a qualified employer in the administration of continuation coverage in which former employees seek to enroll through the SHOP
     - This only includes billing for and collecting premiums directly from the former employee
     - An FF-SHOP may elect to limit this service to only Federally mandated continuation coverage (i.e., COBRA)
   - HHS is considering whether to permit an FF-SHOP to accept premium payment using a credit card
   - SHOP regulations would become aligned with the Protecting Access to Medicare Act of 2014
     - This repealed deductible maximums for employer-sponsored coverage
   - A SHOP that establishes a minimum participation rate is required to establish a single, uniform rate that applies to all groups and issuers in the SHOP
     - This rate would have to be based on the number of employees participating in the SHOP, plus those enrolled in coverage through another group health plan, governmental coverage, coverage sold through the individual market (excluding excepted benefits), or other MEC
     - HHS is considering extending this requirement to the entire small group market
   - Current regulations are being amended to clarify that an eligible employee's dependents are also eligible to enroll through the SHOP, where an employer offers dependent coverage

- QHP issuers would be required to provide notice of the coverage effective date to anyone enrolled in coverage through the SHOP
- State based SHOPs only need to establish effective dates for employees enrolling during the initial group enrollment or annual open enrollment periods
  - Special enrollment periods are standardized by §155.420(b) and would remain unchanged
  - Effective dates for FF-SHOPs would remain as HHS interpreted as applicable under the former rule
- A new employee's enrollment period begins on the date they were first hired
  - The enrollment period would be required to be at least 30 days
  - When the waiting period is more than 45 days, the enrollment period would end 15 days before the conclusion of the waiting period
- The effective date for a new employee would follow the same rules as initial and open enrollments established by the SHOP
- Coverage through a SHOP in states with a merged individual and small group risk pool would be offered on a calendar year basis
  - Employers may continue to purchase group coverage at any point during the calendar year, however all SHOP plans would terminate on December 31st of the year they were issued
- A SHOP may elect, but is not required, to automatically renew a qualified employer's offer of coverage where the employer has taken no action during its annual election period to modify or withdraw prior coverage
  - If the employer is no longer eligible, or offers a single QHP and that QHP would no longer be offered, renewal would not be automatic
- For an FF-SHOP, coverage would terminate for non-payment of premiums on the last day of the month for which full payment was received
- For an FF-SHOP reinstatement for non-payment of premium can only happen once per **calendar** year
- The SHOP would be required to provide notice to the enrollee, the enrollee's dependents, and the employer of termination due to non-payment of premium or loss of eligibility for participation in the SHOP
  - Previously the QHP was responsible for providing this notice
  - The QHP issuer would be required to continue to provide notice of the discontinuation of a product when the QHP is terminated or decertified

7. Exchange Functions: Certification of Qualified Health Plans (pp. 152-153 of the Draft Notice)

- QHP certification would be in effect for the duration of any employer's plan year that began in the calendar year for which the plan was certified

HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

1. General Provisions (pp. 153-155 of the Draft Notice)
   - The user fee rate for 2016 is 3.5% of premium, unchanged from the 2015 fee

2. Essential Health Benefits Package (pp. 155-188 of the Draft Notice)

Benefits and Coverage

- Language related to a default benchmark plan is being deleted for US Territories given it was determined that rules related to EHBs do not apply to the territories
- A uniform definition of habilitative services is being proposed, removing the option for issuers to determine the scope of habilitative services
  - The proposed definition includes "healthcare services that help a person keep, learn, or improve skills and functioning for daily living" that "may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings"
  - If not included in the benchmark plan, the State may determine which services are included in the definition of habilitative services
  - Habilitative and rehabilitative services cannot count toward a common visit limit; separate limits would be required to be established for each
  - Health plans cannot have limits on habilitative services that are less favorable than limits for rehabilitative services
- HHS has clarified that pediatric services would be required to be provided through the end of the plan year in which the enrollee turns 19 years of age
- Age limits are considered discriminatory when applied to services that have been found to be clinically appropriate for all ages
- States would be allowed to select a new benchmark plan for the 2017 plan year
  - States could select a 2014 ACA compliant plan which would already meet the requirements of §156.110 covering EHB
  - HHS is considering allowing states to select a new benchmark plan that is not compliant with §156.110, however the plan would then need to be supplemented to be in compliance
  - HHS would collect details from each state on covered benefits, treatment limitations, drugs covered and exclusions for the new benchmark plans

Prescription Drug Formularies

- Current requirements that formularies contain a certain number of drugs would be replaced
  - Quantitative EHB requirements would be replaced with qualitative requirements
  - Effective starting with the 2017 plan year, issuers would be required to establish a pharmacy and therapeutics (P&T) committee to ensure a plan's formulary covers a sufficient number and type of drugs
  - At least 20% of the committee's membership would be required to not have a conflict of interest with either the issuer or a pharmaceutical manufacturer, and any conflict would need to be disclosed

  - The P&T committee would be required to:
    - Meet at least quarterly
    - Include experts in chronic diseases and care for individuals with disabilities
    - Document their procedures for drug review
    - Make clinical decisions based on scientific evidence
    - Consider drug safety and efficacy when making recommendations as to formulary tier
    - Review both newly FDA-approved drugs and new uses for existing drugs
    - Ensure the formulary covers a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all diseases
  - Formularies would be required to ensure appropriate access to drugs in widely accepted national treatment guidelines which are indicative of general best practices at the time
  - States would be responsible for oversight and enforcement of P&T committee standards
- Standards based on the American Hospital Formulary Service (AHFS) are being considered in addition to or in place of a P&T committee
  - AHFS is a 4-tier hierarchical classification system and has more classifications than the current USP system
  - An issuer's formulary would be required to contain the greater of one drug in each AHFS class and subclass or the same number of drugs in each AHFS class and subclass as the State's EHB-benchmark plan
- Non-formulary drugs that are covered under an "exception process" would be required to be treated as an EHB and corresponding cost sharing would accrue toward the annual limit on cost sharing
  - Determinations for standard exception requests would be required to be made within 72 hours
  - Determinations for expedited exception requests would be required to be made within 24 hours
- Starting in 2016, issuers would be required maintain an up-to-date, accurate and complete list of all covered drugs on their website
  - All tier classifications and restrictions would be required to be reflected
    - HHS is considering requiring cost sharing information be included
  - The information would be required to be easily accessible to the general public without having to create an account or enter a policy number
  - For issuers with multiple formularies, each plan would be required to be clearly mapped to the appropriate formulary
  - HHS may require the information to be available in a machine readable format, either on their website or provided to HHS using a standard template
  - Health plans would be required to maintain a current URL link to accurate formulary information for each benefit plan
- Drug coverage would be required to include the option to fill prescriptions at a retail pharmacy; mail-order only plans would not be considered to meet EHB requirements
  - Differentials in cost sharing requirements between retail and mail-order pharmacies may exist
  - Cost sharing differentials may exist between in-network and out-of-network retail pharmacies
- Starting in 2017, issuers would be allowed to restrict access to a particular drug when the FDA has restricted distribution of the drug to certain facilities or appropriate dispensing of the drug requires special handling, provider coordination, or patient education
  - The requirement for patient education alone is not sufficient to restrict access
  - The publicly available formulary would be required to indicate which drugs have restricted access

- Issuers are encouraged to cover non-formulary drugs currently being taken by new enrollees for their first 30 days of enrollment without imposing any requirements for step-therapies, although it does not appear this would be required

Enrollee Cost Sharing

- Clarification is being provided to indicate that the applicable annual cost sharing limitations are those specific to the calendar year in which a plan year begins
  - Cost sharing limits for non-calendar year plans may not be adjusted mid-plan year when a new calendar year begins
- Annual limit on cost sharing for self-only coverage applies to all individuals, regardless of whether they are covered under a self-only plan or an other than self-only plan
  - Family out-of-pocket limits may still be applied, however each individual within the family would be required to have their cost sharing limited to no more than the limit for self-only coverage
  - Annual limitations would be required to be specific to the calendar year in which coverage begins
- Minimum Value (MV) requirements would be amended to include the requirement that plans provide "substantial coverage of both inpatient hospital services and physician services"
  - The new requirements would not apply before the end of the plan year for plans that, before November 4, 2014, entered into a binding written commitment so long as the plan year begins no later than March 1, 2015

3. Qualified Health plan Minimum Certification Standards (pp. 188-202 of the Draft Notice)

- Revisions to prior regulations are being proposed to clarify that QHPs are responsible for complying with all standards of 45 CR 153 covering reinsurance, risk corridors, and risk adjustment, and not just those pertaining to risk adjustment
- QHPs that have been certified for one benefit year would be required to submit information and make it available to the public in plain language starting in 2016
  - HHS seeks comment on the content of the information and the format in which it should be displayed
- Network adequacy requirements for 2016 would mirror those in the 2015 letter to issuers http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf
  - HHS would consider the NAIC model act relative to network adequacy once it becomes available http://www.naic.org/meetings1411/committees_b_rftf_namr_sg_2014_fall_nm_materials.pdf?1417733687985
  - HHS is encouraging QHP issuers to treat non-network providers as in-network for the first 30 days of coverage for new enrollees
    - Issuers could require that enrollee would have had to have been in course of treatment with the provider during the 90 days prior to the effective date
- Starting in 2016, issuers would be required to maintain an up-to-date, accurate and complete provider directory on their website including provider address, specialty, and medical group affiliation
  - The information would need be easily accessible to the general public without having to create an account or enter a policy number
  - The directory would need to indicate which providers are accepting new patients
  - The directory would need to be updated at least monthly
  - The directory would need to clearly identify which networks apply to which plans
  - HHS may require the information to be available in a machine readable format, either on their website or provided to HHS using a standard template

- The definition of essential community providers (ECPs) would be expanded for 2016 to include:
  - Not-for-profit or state-owned providers described in Section 340B that do not receive federal funding
  - Not-for-profit or governmental family planning sites that do not receive funds under Title X of the PHSA
  - Other providers that provide care to individuals in low income ZIP codes or Health Professional Shortage Areas
- QHP issuers offering coverage through an FFE would be required to:
  - Include in their network a specified percentage of all available ECPs in the plan's service area, as determined by HHS annually
    - Multiple providers at a single location would count as a single ECP for purposes of satisfying the required percentage
  - Offer contracts to all available Indian health providers in the service area and at least one ECP in each of the following five ECP categories as defined in the regulation: Federally Qualified Health Centers, Ryan White providers, family planning providers, hospitals, and other ECP providers
  - QHP issuers that do not meet ECP standards at the time of application would be required to include a justification outlining how they would service individuals in low-income ZIP codes or Health Professional Shortage Areas and how the network would be strengthened prior to the start of the benefit year
- For QHP issuers that provide a majority of services through physicians employed by the issuer or a single medical group:
  - The alternate ECP standard described in §156.235(b) would apply to QHP issuers in any Exchange, requiring "reasonable and timely access"
  - QHP issuers seeking certification through an FFE would be required to also demonstrate that the number of providers in Health Professional Shortage Areas or low-income ZIP codes where at least 30% of the population is below 200% FPL meet a percentage specified by HHS
  - QHP issuers applying for participation in an FFE that do not meet the alternate ECP standard would be required to provide a justification explaining how the QHP's network provides an adequate level of service for low-income and medically underserved enrollees
- Readability and accessibility standards would be expanded beyond just applications and notices to apply to any information provided to applicants, employers, employees and enrollees that is required by State or Federal law
- QHP issuers would be required to collect a separate premium for non-excepted abortion coverage for which public funding is prohibited in the individual market
  - Issuers could separately itemize the premium for abortion coverage, send a separate bill, or send a notice at the time of enrollment specifying the charge for abortion coverage that would be included in the bill
  - The separate charge would be calculated on an average per enrollee per month basis and would be required to be at least one dollar

4. Health Insurance Issuer Responsibility with Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions (pp. 202-211 of the Draft Notice)
   - The maximum annual limitation for cost sharing, the required contribution percentage for MEC, and the large employer penalty are adjusted annually by the percentage by which average per capita premium for health insurance for the prior year exceeds the average per capita premium for health insurance for 2013
     - The 2016 adjustment percentage was calculated to be 8.3%, based on the projected increase of 2015 premium over 2013 premium by the National Health Expenditure Accounts (NHEA) for employer-sponsored coverage
     - Results are rounded to the next lowest multiple of $50; family provisions are twice the single levels

- Maximum out-of-pocket (MOOP) limits for 2016 are $6,850 for self-only and $13,700 for other than self-only coverage
  - MOOP limits for CSR plans for self-only coverage are as follows:

FPL	AV	REDUCTION IN MOOP	2016 MOOP SELF-ONLY	2016 MOOP OTHER THAN SELF-ONLY
100-150%	0.94	2/3	$2,250	$4,500
150-200%	0.87	2/3	$2,250	$4,500
200-250%	0.73	1/5	$5,450	$10,900

- QHP issuers would be required to provide a summary of benefits and coverage (SBC) for all CSR plans starting with the 2016 open enrollment period; new SBCs would be required to be provided to individuals experiencing a change in eligibility within seven business days of receiving a change in eligibility notice from the Exchange
- HHS would allow QHP issuers who cover non-EHBs to estimate the percentage of allowed claims that are for non-EHB services (as reported in the URRT) to adjust the allowed amount for CSR reconciliations
  - Limited to plans that allow non-EHB services to count toward deductibles and the MOOP but for which copayments and coinsurance rates for non-EHB services are not reduced, and where non-EHB services account for less than 2% of all claims

5. Minimum Essential Coverage (pp. 211-213 of the Draft Notice)

- HHS expanded the list of qualifying MEC to include the following:
  - Self-funded student health plans for plan or policy years beginning on or before December 31, 2014
  - Refugee Medical Assistance supported by the Administration for Children and Families
  - Medicare Advantage plans
  - State high risk pools for plan or policy years beginning on or before December 31, 2014
- The previous one-year transitional period applied to state high risk pool coverage has been eliminated to allow states more time to transition individuals into QHPs
  - This is only applicable to state high risk pools in existence. State high risk pools formed after the publication date of this proposed rule would not be recognized as MEC

6. Enforcement Remedies in Federally-Facilitated Exchanges (pp. 213-219 of the Draft Notice)

- The good faith compliance policy for QHP issuers offering coverage through an FFE is extended through calendar year 2014
  - Sanctions would not be applied for QHPs acting in good faith to comply with Exchange requirements
  - HHS would continue to provide technical assistance to QHP issuers with compliance issues
- QHPs would be suppressed and temporarily unavailable for enrollment through an FFE if:
  - The QHP issuer has notified the Exchange that it intends to withdraw the QHP from the FFE, if an allowable exception to guarantee renewability applies
  - When HHS determines the FFE has incorrect data about the QHP
  - QHPs in the process of being decertified or appealing a decertification
  - When the QHP is the subject of a pending, ongoing, or final state regulatory or enforcement action that would affect the issuer's ability to enroll consumers
  - When either the special rule for network plans under §147.104(c) applies or the QHP issuer does not have the financial reserves to offer additional coverage
  - Upon notification by OPM that a multi-state plan compliance violation has occurred

7. Quality Standards (pp. 219-227 of the Draft Notice)
   - HHS proposes to establish quality improvement strategy (QIS) standards that use market based incentives for QHPs offered through the Exchanges
     - Standards are intended to align with National Quality Strategy, CMS Quality Strategy, and other Federal, State and private sector initiatives
   - The development of new QIS standards would be guided by the following principles:
     - The QIS would focus implementing on one or more of the following:
       - Improving health outcomes
       - Activities to prevent hospital readmissions
       - Activities to improve patient safety and reduce medical errors
       - Wellness and health promotion activities
       - Activities to reduce health and healthcare disparities
     - HHS would seek to minimize administrative burdens on QHP issuers
     - Standards would be flexible to encourage QHP issuer innovation and promote a culture of continuous quality improvement
     - Standards would be flexible so that state based Exchanges can build additional reporting requirements, as needed
     - Standards would be public and transparent
   - Starting in 2016, QHP issuers participating in an Exchange for at least two years would be required to submit a QIS implementation plan with annual progress updates, including the payment structure to provide increased reimbursement or other market-based incentives such as:
     - A rationale that describes the relevance of the QIS to the QHP's population
     - Proposed performance measures and targets
     - Activities to reduce health and healthcare disparities
     - Other information about barriers and mitigation planning, for example the percentage of provider payments that is adjusted based on quality and cost of services
   - HHS proposes to phase in the QIS standards and reporting requirements, and may require only those QHP issuers meeting a minimum enrollment size would be required to comply

8. Qualified Health Plan Issuer Responsibilities (pp. 227-230 of the Draft Notice)
   - HHS is revising the process for a hearing related to a reconsideration of decisions regarding payments and charges for premium stabilization programs, CSR reconciliation payments and charges, and assessments of default risk adjustment charges
     - When the hearing officer upholds the reconsideration decision, either the issuer or CMS may now request a review by the Administrator of CMS within 15 calendar days, just as the QHP issuer may
     - The Administrator of CMS may decline the request to review the decision of the CMS hearing officer
     - The Administrator's decision is final and binding

ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

1. Treatment of Cost-Sharing Reductions in MLR Calculations (pp. 230-231 of the Draft Notice)
   - Clarification was added to indicate that CSR payments should be deducted from incurred claims under the MLR program

2. Reporting of Federal and State Taxes (pp. 231-232 of the Draft Notice)
   - The Notice clarifies that both the employer and employee's share of employment taxes such as FICA, RRTA, FUTA, State unemployment taxes, and other similar taxes more directly related to overhead than health insurance may not be deducted from premium in the MLR calculation

3. Distribution of Rebates to Group Enrollees in Non-Federal Governmental Plans (pp. 232-233 of the Draft Notice)
   - Group policyholders of non-Federal governmental plans or other group health plans not subject to ERISA receiving MLR rebates would be required to distribute or use the rebates to the employee's benefit within three months of receipt of the rebate

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