

## **Proposed HHS Notice of Benefit and Payment Parameters for 2016 Fact Sheet**

The proposed 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.

Qualified individuals and employers are now able to shop for private health insurance coverage through the Health Insurance Marketplaces (Marketplaces). Open enrollment for coverage in 2015 is currently underway, and consumers are shopping and enrolling at HealthCare.gov. Today's proposed rule generally addresses coverage that will be available to consumers in 2016.

Key policies in today's proposed 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) 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 the state regulator or HHS to determine whether they are unreasonable. Currently, we determine which increases must be reviewed at the "product" level. An example of a "product" would be an issuer's individual market PPO product, which could include many plans at many metal levels. We propose instead to trigger a review at the "plan" level by requiring disclosure and review whenever a plan within a product experiences a rate increase that meets or exceeds the applicable threshold. An example of a "plan" would be an issuer's particular silver level plan. We also propose an approach to ensure that issuers submit, and states with Effective Rate Review Programs display on their websites, information about all rate increases in the individual and small group markets for both QHPs and non-QHPs on a uniform timeline, though states would have the flexibility to establish earlier submission and posting timeframes.

### **Eligibility, Enrollment, and Benefits**

**Annual Open Enrollment Period:** We propose to set the open enrollment period for non-grandfathered policies in the individual market, inside and outside the Marketplace, for all benefit years beginning on or after January 1, 2016, so that it begins on October 1 and runs through December 15 of the year prior to the benefit year.

**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 to permit individuals eligible for services from an Indian health care provider to claim a hardship exemption through the tax filing process. We anticipate that the IRS will finalize these processes in time for 2014 tax filings.

**Habilitative Services:** We propose to define habilitative services using the same definition currently used in the Glossary of Health Coverage and Medical Terms available on the healthcare.gov website.

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**Revised EHB Benchmark Selection:** We propose that states select new benchmark plans for 2017, based on plans available in 2014.

**Pediatric Age:** We propose that pediatric benefits be provided until the end of the plan year in which the enrollee turns 19.

**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. We are proposing to replace this standard with one based on a pharmacy and therapeutic (P&T) committee system, under which issuers would design their formularies using scientific evidence that would 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. As an alternative to, or in combination with, the P&T committee proposal, we are seeking comments on whether we should use another drug count standard based on the American Hospital Formulary Service, or whether we should retain the current USP drug count.

**Formulary Drug List:** We propose to clarify 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. We seek comment on the best way to make this information available in standard machine-readable formats.

**Drug Exceptions Process:** Our current regulation requires that issuers have processes through which an enrollee can request and gain access to a drug not on the formulary. We propose to establish more detailed procedures for the standard review process, and to require an external review if the health plan denies an initial request made on a standard or expedited basis. We also clarify that cost sharing for drugs obtained through the exceptions process must count towards the annual limitation on cost sharing.

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

**Essential Health 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 that we will identify specific practices that may be considered discriminatory, including restricting services based on age when they may be appropriate for all ages, and placing 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 conduct certify QHPs.

**Determination of Minimum Value:** Consistent with our recently published guidance, we propose that, in order to provide minimum value, a plan must not only cover a predicted 60 percent of the allowed costs under the plan, but must also provide a benefit package that reflects benefits historically provided

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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 issuers that because a full year of claims data will be available, they must make certain information available as part of the 2016 certification process. We are seeking comment on that data collection process.

**Default Re-Enrollment:** Under current rules, consumers who do not take action during the open enrollment window are re-enrolled in the same plan they were in the previous year, even if that plan experienced significant premium increases. We are considering alternative options for re-enrollment, under which consumers who take no action might be defaulted into a lower cost plan rather than their current plan. We are considering allowing states to pursue these sorts of re-enrollment alternatives for coverage in 2016. The FFM is exploring such an approach for coverage in 2017.

**Meaningful Access Standards:** We propose to specify that, for Marketplaces, QHP issuers, and web-brokers, their existing general requirement to provide “oral interpretation” services would include providing telephonic interpreter services in at least 150 languages. The FFM call center is already meeting 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 propose that a provider directory is 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. We also seek comment on the best way to make this information available in standard machine-readable formats.

**Essential Community Providers:** We propose to codify the standard used for 2015 for the FFM, that issuers seeking qualified health plan certification in the FFM subject to the general essential community provider standard would 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 propose to codify and update annually the 2015 FFM policy that provides a 30% percentage threshold for 2015 though 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:** We propose that QHP issuers 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. We also propose that QHP issuers provide all information that is critical to obtaining health insurance coverage or accessing health care services in a manner that is consistent with the meaningful access requirements.

**Quality Improvement Strategy (QIS):** To obtain QHP certification, each issuer must implement a quality improvement strategy, which is a payment structure that provides increased reimbursement or other

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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. We propose that a QHP issuer participating in a Marketplace for at least two years be required to implement and report information regarding a quality improvement strategy. We propose to direct QHP issuers to submit data annually for activities that are conducted in relation to implementation of its QIS.

**Strengthening the MLR Program:** We propose to require that subscribers of non-federal governmental or other group health plans not subject to ERISA 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. In addition, we are proposing technical clarifications to the MLR rule to ensure that issuers correctly exclude from MLR and rebate calculations the federal and state employment taxes, as well as the cost-sharing reduction payments issuers receive from HHS.

**SHOP:** This proposed rule includes provisions to streamline the administration of the SHOP. First, the proposed rule would permit SHOPS to assist employers in the administration of continuation coverage (COBRA) enrolled in through a SHOP. Second, based on input from stakeholders, we propose to permit a SHOP 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 propose to modify 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 propose to align 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 also propose an exception to the rule regarding 12-month plan years in the SHOP for states with merged individual and small group risk pools. We also propose to specify 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 propose to specify that certain notices will be provided by the SHOP.

**Payment Parameters**

**Promoting Stable Individual Market Premiums:** In the 2015 Payment Notice, we finalized the 2015 reinsurance payment parameters – an attachment point of \$70,000, a reinsurance cap at \$250,000, and a coinsurance rate of 50 percent. In the Exchange and Insurance Market Standards for 2015 and Beyond Rule, we stated that we intended to propose a reduction in the 2015 attachment point in future rulemaking. We are now proposing to 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 proposing to raise the attachment point to \$90,000, hold the reinsurance cap at \$250,000, and maintain the coinsurance rate of 50 percent. We are proposing a 2016 per capita reinsurance contribution rate to be paid by health insurance issuers and certain self-insured group health plans on behalf of their enrollees of \$27 annually.

**2016 User Fees:** HHS collects a user fee from participating issuers to fund FFM 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 should also be set at 3.5 percent of the monthly premium charged by the issuer.

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**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 propose 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.

**Maximum Annual Limitation on Cost Sharing:** We propose a 2016 maximum annual limitation on cost sharing of \$6,850 for self-only coverage, and \$13,700 for other than self-only coverage. We also clarify that the annual limitation on cost sharing applies for the plan year and not the calendar year for non-calendar year plans, and that issuers are permitted but not required to count out-of-network cost sharing to against the annual limitation on cost sharing.

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

**Required Contribution Percentage:** Based on the premium adjustment percentage, we propose an 8.1 percent required contribution percentage for 2016 under Section 5000A of the Internal Revenue Code. If an individual must pay more than the required contribution percentage of his or her household income towards minimum essential coverage, the individual is not required to make the shared responsibility payment.

**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 proposing to update the benefit year 2016 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 propose that common ownership be defined according to section 414(b) and (c) of the Internal Revenue Code.

**Self-insured Expatriate Plans:** Insured expatriate plans do not make reinsurance contributions. We propose that self-insured expatriate plans also not be required to make reinsurance contributions for the 2015 and 2016 benefit years.

**Clarification on Risk Corridors:** We propose a clarification to 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 late 2014 and becomes a transitional plan.

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**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 propose to implement an adjustment to the profit floor and administrative cost ceiling to increase risk corridors payments for eligible issuers for benefit year 2016. This adjustment would only be available to issuers whose medical loss ratios (MLR) meet or exceed the 80 percent MLR threshold (and are generally eligible for risk corridors payments) for the 2016 benefit year. 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 would make a clarification to specify that the requirement of 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 Training for Agents and Brokers:** We propose processes under which HHS would recognize the successful completion of an Exchange 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 proposal, HHS would 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 propose that to become an HHS-approved vendor, the organization must demonstrate that it meets specified criteria pursuant to an approval process established by HHS.

**Good Faith Compliance Extension through 2015 for QHPs in FFMs:** We propose to extend the good faith compliance policy that was adopted for the 2014 calendar year through the 2015 calendar year.