ACA COMPLIANCE BULLETIN

HIGHLIGHTS

- For 2017, the ACA's out-of-pocket maximum increases to $7,150 for self-only coverage and $14,300 for family coverage.
- A new Exchange model is available for state-based Exchanges relying on the federal www.healthcare.gov platform.
- Beginning in 2017, the final rule establishes six standardized plan options in the individual market federal Exchanges.

IMPORTANT DATES

November 1 – January 31

The 2017 and 2018 open enrollment period will run from Nov. 1 of the preceding year through Jan. 31 of the benefit year.

November 1 – December 15

The open enrollment period for 2019 and later years will run from Nov. 1 – Dec. 15 of the preceding year.

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2017 NOTICE OF BENEFIT & PAYMENT PARAMETERS

OVERVIEW

On Feb. 29, 2016, the Department of Health and Human Services (HHS) released its **final Notice of Benefit and Payment Parameters for 2017**. This rule describes benefit and payment parameters under the Affordable Care Act (ACA), applicable for the 2017 benefit year, including standards relating to:

- Annual limitations on cost-sharing; and
- The open enrollment period in the Exchange for 2017 and later years.

The rule also includes the following key changes for 2017:

- Incorporates new definitions of "large employer" and "small employer," consistent with the Protecting Affordable Coverage for Employees (PACE) Act;
- Recognizes a new Exchange model; and
- Creates standardized benefit plan options in the federally facilitated Exchange (FFE).

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Annual Limitations on Cost-sharing

Effective for plan years beginning on or after Jan. 1, 2014, the ACA requires non-grandfathered plans to comply with an overall annual limit—or an out-of-pocket maximum—on essential health benefits (EHB).

The ACA requires the out-of-pocket maximum to be updated annually based on the percent increase in average premiums per person for health insurance coverage.

- For 2016, the out-of-pocket maximum is **$6,850 for self-only coverage** and **$13,700 for family coverage**.
- Under the final rule, the out-of-pocket maximum increases for 2017 to **$7,150 for self-only coverage** and **$14,300 for family coverage**.

Large Employer and Small Employer Definitions

As it was passed, the ACA included the following definitions of "large employer" and "small employer":

Large Employer	Employed an average of at least 101 employees on business days during the preceding calendar year, and employs at least one employee on the first day of the plan year
Small Employer	Employed an average of between one and 100 employees on business days during the preceding calendar year, and employs at least one employee on the first day of the plan year

Prior to Jan. 1, 2016, the ACA allowed states to elect to define a "large employer" as one with more than 50 employees, and "small employer" as one with 50 or fewer employees. However, these definitions were amended by the PACE Act on Oct. 7, 2015.

As a result, the final rule revised the regulatory definitions of "large employer" and "small employer" to conform to the PACE Act. Specifically:

- The definition of "large employer" is revised to mean an employer with an average of **at least 51 employees** during the preceding calendar year.
- The definition of "small employer" is revised to mean an employer with an average of **between one and 50 employees** during the preceding calendar year.

However, the final rule allows states to elect to define a "large employer" as one with more than 100 employees, and a "small employer" as one with 100 or fewer employees. The final rule also clarifies that an employer that was not in existence during the preceding calendar year determines whether it is a "large employer" or "small employer" based on the average number of employees that it is reasonably expected to employ during the current calendar year.

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Small Business Health Options Program (SHOP)

For 2016, employers offering coverage through a federally facilitated SHOP (FF-SHOP) have two options for providing coverage—they can offer:

- ✓ A single plan; or
- ✓ A "horizontal" choice, where an employer selects a single actuarial value coverage level and makes all plans at that coverage level available to the qualified employees.

For plan years beginning on or after Jan. 1, 2017, the final rule adds an additional employer choice option in FF-SHOPs, called a "vertical choice" option. This vertical choice allows employers to offer qualified employees a choice of all plans across all available levels of coverage from a single issuer.

However, states that have FF-SHOPs may recommend that the FF-SHOP in their state not offer vertical choice. In addition, states that have state-based SHOPs using the federal platform for SHOP enrollment functions can opt out of making vertical choice available in their states. State-based SHOPs not using the federal platform have the flexibility to provide employers with vertical choice, or other options for providing employer choice in addition to "horizontal" choice.

SHOPs in all states are still required to allow employers to offer horizontal choice.

Exchange Open Enrollment Period for 2017 and Later Years

The final rule identifies the annual open enrollment period for non-grandfathered policies in the individual market, inside and outside of the Exchange, for 2017 and 2018. Under the final rule, the annual open enrollment period for 2017 and 2018 corresponds to the open enrollment period for 2016, beginning on Nov. 1 of the preceding year, and ending on Jan. 31 of the benefit year.

The rule finalizes a shorter open enrollment period for the 2019 and later benefit years, so that it will begin on Nov. 1 and run through Dec. 15 of the year preceding the benefit year.

As a result:

- The 2017 open enrollment period will begin on **Nov. 1, 2016**, and run through **Jan. 31, 2017**.
- The 2018 open enrollment period will begin on **Nov. 1, 2017**, and run through **Jan. 31, 2018**.

The rule also finalizes the open enrollment period for the 2019 and later benefit years, adopting a shorter duration for the open enrollment period. Under the final rule, the open enrollment period for 2019 and later years will **begin on Nov. 1 and run through Dec. 15 of the year preceding the benefit year**.

According to HHS, this policy will provide continuity in the short run as well as sufficient time for all entities involved in the annual open enrollment period process—including Exchanges and issuers—to make the necessary adjustments to meet this earlier deadline.

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New Category of Exchange

Under the ACA, states could choose one of the following three models for their Exchange:

1. Create and operate their own **state-based Exchange (SBE)**;
2. Have HHS operate an **FFE** for its residents; or
3. Partner with HHS to create a **partnership Exchange**, so that some FFE functions are performed by the state.

The final rule adds an additional Exchange model—**a state-based Exchange on the federal platform (SBE-FP)**—to enable SBEs to conduct certain processes using the federal eligibility and enrollment technology infrastructure on www.healthcare.gov. Under the final rule:

- ✓ The SBE-FP is primarily responsible for plan management functions, consumer assistance and outreach, ongoing oversight and program integrity, and ensuring that all Exchange requirements are met.
- ✓ Through the federal platform, www.healthcare.gov, HHS will be responsible for eligibility determinations, enrollment processing activities and associated federal platform services.

HHS will collect user fees to cover federal costs in states that choose to use the SBE-FP model. SBE-FPs will be required to enforce certain plan and issuer requirements that are no less strict than the requirements that HHS applies in the FFEs, and HHS will retain the authority to suppress plans on www.healthcare.gov in the appropriate circumstances.

Currently, four states—Hawaii, Oregon, Nevada and New Mexico—have established SBEs that rely on the www.healthcare.gov platform.

Standardized Plan Options

The final rule creates **six "standardized benefit plan options"** in the individual market FFE, in an effort to simplify the plan selection process by allowing consumers to more easily compare plans across issuers in the FFE. These standardized options would include:

- ✓ One bronze standardized option;
- ✓ One silver standardized option;
- ✓ A separate standardized option for each silver plan variation (73 percent, 87 percent and 94 percent) available to individuals who are eligible for cost-sharing reductions; and
- ✓ One gold standardized option.

These plans will have a single provider tier, a fixed in-network deductible, a fixed annual cost-sharing limit and standardized copayments and coinsurance for a key set of EHB that comprise a large percentage of the total allowable costs for an average enrollee.

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Issuers are not required to offer standardized options in 2017, and are still permitted to offer non-standardized plans. HHS is currently conducting consumer testing to determine how these plans will be displayed on www.healthcare.gov.

Individual Mandate's Affordability Exemption

Under the ACA, individuals who lack access to affordable minimum essential coverage (MEC) are exempt from the individual mandate penalty. For purposes of this exemption, coverage is considered affordable for an employee if the required contribution for the lowest-cost, self-only coverage does not exceed **8 percent of household income**.

This required contribution percentage is adjusted annually after 2014. For 2015, the required contribution percentage is **8.05 percent of household income**. For 2016, the required contribution percentage is **8.13 percent of household income**.

For 2017, the final rule provides that an individual is exempt from the individual mandate penalty if he or she must pay more than **8.16 percent of his or her household income** for MEC.

Medical Loss Ratio Rules

The ACA's medical loss ratio (MLR) rules require health insurance issuers to spend 80 to 85 percent of their premium dollars on medical care and health care quality improvement activities, or pay rebates to enrollees.

Previous MLR regulations required issuers to report incurred claims within a **three-month run-out period**. This run-out period is intended to improve the accuracy of reported incurred claims by using actual claims payments that take place during the run-out period—instead of estimated claims liabilities and reserves—in the calculation of claims incurred in the reporting year.

However, MLR reports are not due to HHS until **July 31** of the year following the reporting year. Because of this, the proposed rule notes that the incurred claims valuation can occur later in the year in order to provide a more accurate MLR calculation by reducing reliance on estimates.

The proposed Notice of Benefit and Payment Parameters for 2017 proposed to amend the reporting requirements for incurred claims to use a six-month run-out period (rather than three-month), beginning with the 2015 reporting year. The final rule, however, **retains the existing three-month run-out period**, and indicates that HHS will explore ways to restore the earlier MLR deadlines in the future.

In addition, the proposed rule requested comments on whether an issuer should be **permitted to count investments in fraud-prevention activities as incurred claims** for MLR reporting purposes. Currently, issuers are only permitted to include amounts recovered through fraud-reduction efforts, up to the amount of fraud-reduction expenses, in incurred claims when calculating the MLR. The final rule **did not adopt this change**.

Source: Department of Health & Human Services

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