CLIENT ALERT

2017 Payment Rule Signals Increased Federal Oversight as Exchanges Evolve

Dec.01.2015

CMS will publish the Notice of Benefit and Payment Parameters for 2017 ("2017 Payment Rule" or "Proposed Rule"), the annual rulemaking that contains proposals to refine the administration's policy for health coverage under the Affordable Care Act, on December 2, 2015. Interested parties have until December 21, 2015 to file comments. CMS published a fact sheet on the Proposed Rule here. Portions of the Proposed Rule apply directly to the Federally-facilitated exchanges (which currently serve 27 States); other aspects apply to all qualified health plans (QHP) as well. A number of the more significant proposed changes restrict flexibility in defining plan terms and provider networks. Other changes respond to specific concerns by enrollees and plans. Here is a brief summary of some of the more notable provisions:

Standardized Plan Options Introduced

CMS plans to introduce standardized plan cost-sharing structures for 2017 plans sold in the individual market on Federally-facilitated exchanges (FFEs) in order to simplify comparison shopping. The standardized cost-sharing structures would apply to a key set of essential health benefits (EHBs) that comprises a large portion of the costs for the average enrollee. Use of standardized plans would be optional for 2017, but standardized plan options would be distinguished from non-standardized plans on FFE websites for that plan year. Standardized plans would include: (i) a single provider tier; (ii) a fixed in-network deductible; (iii) a fixed annual limitation on cost-sharing; and (iv) standardized copayments/coinsurance for a key set of EHBs. Standardized designs would be provided for the bronze, silver and gold tiers, with three additional variations for the silver tier to account for the three different levels of cost-sharing reductions. The standardized designs would prefer the use of copayments over coinsurance, to reflect consumer preferences. Routine services, such as primary care, specialist visits, and generic drugs, would be exempted from deductibles.[1]

Federally-facilitated Exchanges Moving Toward Active Purchaser Model

The 2017 Payment Rule raises the possibility of CMS shifting from an open market approach under which any QHP could offer products on an exchange to a more selective active-purchaser model. Under an active purchaser model, like the one used by Covered California, the exchange may deny certification to issuers in order to restrict the number of plans available on the exchange. Although Federally-facilitated exchanges currently may deny certification of QHPs based on solvency, program integrity, and other reasons, the Proposed Rule would represent a significant shift in how CMS administers the FFEs.

Together with the standardized plan options, the active purchaser model would enable CMS to limit the number of plans and types of products offered, to enable consumers to make more focused choices. But CMS' proposed active-purchaser authority may have limited efficacy in certain markets. Healthcare.gov already has seen a reduction in the total number of plans offered on the Federally-facilitated exchanges as some issuers have shifted focus from PPO to HMO products.[2]

Network Adequacy for Exchange Plans

Since the enactment of the Affordable Care Act (ACA), network adequacy has become an increasing concern for consumers, regulators, providers, and health plans in both government programs and the commercial market. The Proposed Rule acknowledges this and would establish clear network adequacy standards for the FFE.

The 2017 Payment Rule would shift from open-ended policy statements about network adequacy—such as the ACA's requirement that all plans offered on an exchange have enough providers so that "all services will be accessible without unreasonable delay"—to quantitative measurements to assess whether consumers have sufficient access to healthcare. The Proposed Rule calls for States to establish measurement criteria to gauge QHP issuers' network adequacy. CMS explains that for States that do not review network adequacy or that have failed to select an appropriate standard, it will use at least the following criteria: county-specific travel time and distance metrics for specific provider and facility types; and minimum ratios of consumers to providers for the highest utilized provider specialties in the State. Plans that fail to satisfy these requirements may submit a justification to request a variance.[3]

Premium Rates, Guaranteed Availability, and Guaranteed Renewability

The Proposed Rule offers several changes and clarifications for rate setting, guaranteed availability, and guaranteed renewability.

The ACA's fair health insurance premium requirement, in PHSA Section 2701 and 45 C.F.R. § 147.102, limits rate setting factors in the individual and small group markets to four criteria: age, geographic region, tobacco use, and family size. Currently, small group plans offered to an employer use the employer's principal place of business to determine the rating area. The Proposed Rule would permit an issuer to use the business address where the greatest number of employees work or, if there is no such address, an address reflective of where most employees live (and as identified by the employer), at the beginning of the plan year to determine the rating area.[4]

The Proposed Rule also would subject non-grandfathered plans in the individual and small group market to rate review beginning in 2017. If the average rate increase (including the four rating factors discussed above) for all enrollees weighted by premium volume for any plan within the product exceeds "the applicable threshold for review" (which is likely 10 percent), then the rate increase will be subject to review. CMS explained that it will review the underlying rates used to develop the premiums.[5]

The Proposed Rule further states that, beginning in 2017, issuers must submit rate filings to CMS using the Unified Rate Review Template (part I of the Rate Filing Justification) for all products in the individual and small group markets—regardless of whether there is an increase, decrease, or no change to a product's premium rate. CMS explained that it needs this information in order to better understand and assess the impact of premium rate increases by contextualizing them in the entire market and taking into consideration the impact of premium decreases. CMS will make the rate filings publicly available to the extent the filings are not trade secrets or contain confidential commercial or financial information. CMS will deem a State to have an effective rate review program if the State makes information about proposed rate increase and final rates publicly available and at a uniform time.[6]

The ACA requires issuers to guarantee the availability of their non-grandfathered products to all applicants—subject to certain exceptions. The Proposed Rule would add another exception to this requirement: when an issuer has given 90-day notice that it is discontinuing a product or 180-day notice that it is exiting the market, the issuer would no longer be required to accept applicants for coverage under the product. Likewise, the Proposed Rule would allow issuers to refuse to accept groups that had violated a group participation or employer contribution requirement or no longer participate in an association. These common-sense exceptions would harmonize guaranteed availability exceptions with guaranteed renewability exceptions, which already allow issuers not to renew in these circumstances.[7]

Risk Adjustment, Reinsurance, and Risk Corridors

To incentivize insurers to offer Exchange plans, the ACA includes three risk-reduction programs—popularly known as the "3Rs." In recent sessions, Congress has reduced the funds available to pay Federal obligations to issuers under each of these programs. These funding issues notwithstanding, the Proposed Rule contains several additional tweaks for issuers.

- **Risk Adjustment program**: This is the only permanent program among the 3Rs. It transfers funds from the lower to the higher risk non-grandfathered individual and small group plans within and without the Exchanges. The preamble indicates that CMS has no plan to change the basic formula used to calculate risk adjustment transfers. However, it proposes several tweaks including taking services in the "preventative" category into account when calculating risk adjustment scores. The effect would be to increase costs and risks for enrollees with greater use of these services, such as younger women and persons in plans with higher cost-sharing, such as silver and bronze plans.[8]
- **Reinsurance program**: This three year program uses reinsurance fees collected from Exchange plans to fund a fairly traditional reinsurance program. The Reinsurance program has been fully funded and actually has more than sufficient funds on hand to pay claims in full. Under the Proposed Rule, CMS intends to redistribute any unused funds in the program to program participants by lowering the attachment point for 2016 to $90,000.[9]
- **Risk Corridor program**: This program provides Federal subsidies to issuers if their actual net profit from QHPs falls sufficiently below a targeted profit level, and requires payments from issuers if their net profit rises sufficiently above targeted profit levels. In determining incurred claims, issuers use estimates for factors such as unpaid claims and receivables from the Federal government for the Cost Sharing Reduction (CSR) program. Under the Proposed Rule, issuers would be required to true-up these estimates based on later data and report an adjustment for the following plan year.

Medical Loss Ratio: Fraud Prevention as Incurred Claims?

The Proposed Rule invites comments on whether CMS should modify the medical loss ratio (MLR) rules to allow issuers to consider fraud prevention activities as incurred claims (the numerator). This development is surprising given that both the NAIC and CMS rejected this concept during the development of the MLR rules in 2010 and 2011. Currently, issuers may include the amounts of claims payments recovered through fraud reduction efforts up to the amount of their fraud reduction expense.[10]

The 2017 Payment Rule also would amend the definition of unpaid claims reserves and the requirements for reporting unpaid claims to use a 6-month, rather than 3-month, run-out period. It also would require issuers to true-up claims liabilities and

reserves used to determine allowable costs for the prior benefit year. The proposed changes are intended to provide more accurate MLR and risk corridors calculations.[11]

Agents and Brokers

The 2017 Payment Rule proposes several changes affecting agents and broker. The Proposed Rule delineates when an FFE may terminate an agent's or broker's agreement for cause. If CMS determine that an agent or broker is noncompliant with applicable standards or has engaged in a pattern of noncompliance, CMS may terminate the agent's or broker's agreement with 30-days' notice, subject to the agent's or broker's right to appeal. Agents and brokers also may face civil monetary penalties if they provide false information to the exchange or disclose a consumer's personally identifiable information. If a State or Federal agency makes a credible allegation of fraud against an agent or broker, CMS may immediately suspend the agent's or broker's activities for up to 90 days while the alleged fraud is investigated. If CMS reasonably confirms the allegation of fraud, CMS may terminate the agent or broker immediately.[12]

CMS has proposed standards of conduct for agents and brokers to protect consumers and increase the efficiency of exchange operations. The proposed standards address topics including: the provision of correct information to consumers; nondiscrimination, and other consumer protections.[13]

The 2017 Payment Rule would change how web brokers enroll consumers and allow consumers to complete the enrollment application while remaining on the web broker's or insurer's website while the web broker or insurer obtains the eligibility information from the exchange using the Federally-facilitated exchange single streamlined application.[14]

Finally, the Proposed Rule would revise how vendors provide training to agents and brokers. Vendors would no longer be required to perform information verification (such as confirmation of State licensure) of agents and brokers. Vendors would be required to provide technical support to agents and brokers who are using the vendor's training platform.[15]

Essential Health Benefits

The Proposed Rule does not make major changes to the scope of essential health benefits. However, it does clarify State responsibility for funding State-mandated benefits. Under CMS' approach, States were to select benchmark plans that would provide the standard for EHBs in their State. If a benchmark plan didn't include certain classes of mandatory EHBs, such as habilitative services, States could add supplementary benefits to fill in the deficit. To the extent that a benchmark plan included additional State-mandated benefits that were not included in the list of Federal EHBs, these state mandates could still be included within the scope of benefits covered by federal subsidies, such the premium tax credit program—so long as the State mandate was in effect as of December 31, 2011. If a State mandated a benefit that took effect after this date, the State was required to defray the cost.

In the 2016 Payment Notice, CMS instructed States to select new benchmark plans for 2017. These plans have now been selected and published by CCIIO.[16] Under the Proposed Rule, to the extent that a 2107 benchmark plan includes new State-mandated benefits that were not in effect as of December 31, 2011, the State must identify these and defray the cost. The exception is if the new benefit was enacted to comply with Federal requirements. One example of such a Federal requirement would be "removal of discriminatory age limits from existing benefits."[17]

Updates to Premium Adjustment Percentage and Cost-Sharing Limits for 2017

The Proposed Rule states that the premium adjustment percentage, which measures average premium increases since 2013, will be set at 13.2 percent for 2017. This factor is used for several calculations, including employer penalties (assessable payment amounts) for not providing ACA-compliant health coverage (*see* 26 U.S.C. § 4980H), and for the annual cost-sharing limits for QHPs. Applying this percentage, the Proposed Rule states that the cost-sharing maximum for 2017 will be $7,150 for self-only coverage and $14,300 for other coverage.[18]

Under the CSR program, cost-sharing maximums have been reduced by 2/3 for persons with household incomes between 100-200 percent of the Federal Poverty Level (FPL) and by 1/2 for persons with household incomes between 200-250 percent of the FPL. Based on an analysis of recent data, the preamble proposes only giving a 1/5 CSR reduction for persons with household incomes of 200-250 percent FPL. This would mean that for 2017, persons with household incomes of 100-200 percent of the FPL would have a maximum cost-sharing of $2,350, while persons with household income of 200-250 percent FPL would have a maximum cost-sharing of $5,700.[19] This could result in a dramatic decrease in benefits for a small increase in household income.

Consumer Protections

The Proposed Rule proposes a number of consumer protections:

- **Reenrollment hierarchy**: After their annual redetermination of eligibility, enrollees are generally required to be automatically reenrolled in the same product with the QHP. Under the Proposed Rule, at the time of initial enrollment, enrollees would be given the option to reenroll in the lowest-cost plan in the service area, instead of their prior plan. CMS recognizes that this proposal could result in surprises to enrollees and administrative problems for plans, and asks for comments on it.[20]
- **Termination by enrollee**: An enrollee would be permitted to retroactively terminate enrollment in an exchange plan within 60 days after the enrollee's discovery of: (i) a technical error which prevented earlier termination, (ii) an error by the exchange, CMS or related agencies that resulted in erroneous enrollment, or (iii) fraud by a third party that resulted in nonconsensual enrollment.[21]
- **Review process for non-formulary drugs**: The preamble proposes to streamline the "exception" process for an enrollee to obtain non-formulary drugs. Under the proposal, where a State subjects appeals for non-formulary drugs to the standard external review process, an enrollee would not have to also satisfy Federal regulations to qualify for an exception.
- **Continuity of care**: The preamble proposes that plans be required to notify members 30 days prior to termination of a provider, or as soon as practicable. Plans would also be required to provide for continuity of care for up to 90 days where the provider was terminated without cause.[22]
- **Out-of-network (OON) providers**: The preamble proposes that where a member inadvertently uses an OON network provider (such as an OON anesthesiologist at an in–network (INN) provider) any cost-sharing paid by the enrollee would count toward the enrollee's annual cost-sharing limit. Alternatively, the plan could give the enrollee prior notice that an OON provider might be encountered at the INN facility.[23]
- **Patient safety**: The preamble proposes that QHPs be required to verify that contracted hospitals with over 50 beds use a patient safety evaluation system which reports to a Patient Safety Organization. QHP would also be required to ensure

that such hospitals have implemented a comprehensive person-centered discharge system to improve care coordination and health care quality for each patient. (The Proposed Rule also provides some flexibility on these standards).[24]

- **Third-party payment of premiums**: The preamble affirms an earlier CMS requirement that plans accept third-party premium payments from Federal government programs—and provides a very broad definition of such programs. The preamble adds that CMS is considering making plans accept third-party payments from charities, as well. The preamble also contains proposals to require plans (*e.g.*, via PBMs) to directly accept cost-sharing subsidies.[25]

Other Notable Developments

- **State-based Marketplace on the Federal platform**: The Proposed Rule would formally recognize a new type of exchange, the State-based Marketplace on the Federal platform (SBE-FP). The SBE-FP is a State-based exchange that relies on the Federal technology platform, such as healthcare.gov, for the eligibility and enrollment functions. States would maintain responsibility for certain functions, such as plan management and consumer assistance and protection.
- **First month premium**: CMS proposes that the first month payment for coverage must be made no earlier than the coverage effective date and no later than 30 days after the issuer receives the enrollment transaction or coverage effective date, whichever is later.[26]
- **Open enrollment period**: The open enrollment period for the individual market for 2017 would begin on November 1, 2016 and end on January 31, 2017.[27]
- **Navigators**: The Proposed Rule contains substantial modifications and enhancements for Navigators. Navigators would be required to provide assistance to consumers even after completion of an application, such as by assisting with eligibility appeals. Navigators also would be required to undertake training to conduct outreach and enrollment activities with underserved and vulnerable populations. CMS would allow each exchange to identify and define underserved and vulnerable populations in its service area.[28]

Conclusion

Many of the proposals reflect theoretical approaches to regulation that may never make it into the Final Rule, which is expected to be published in February 2016.

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[1] HHS, Patient Protection and Affordable Care Act; HHS Notice of Benefit Payment Parameters for 2017, Proposed Rule (hereafter, "Proposed Rule") at 198-204.

[2] *Id*. at 196-98.

[3] *Id*. at 11-12, 222-26. (The proposed network adequacy standards also include proposals for continuity of care. *See* discussion in the "Consumer Protections" section below).

[4] *Id*. at 33-34.

[5] *Id*. at 95-96.

[6] *Id*. at 96-100.

[7] *Id*. at 36-38.

[8] *Id*. at pp. 46-48.

[9] *Id*. at pp. 77-78.

[10] *Id*. at 260-61.

[11] Id. at 259-60.

[12] Id. at 136-39.

[13] Id. at 139-42.

[14] *Id*. at 134-35.

[15] *Id*. at 144-46.

[16] *See* Proposed Rule at 106.

[17] Proposed Rule at 105-09.

[18] *Id*. at 216.

[19] *Id*. at 217-218.

[20] *Id*. at 157-159.

[21] *Id*. at 164-67; 342-44.

[22] *Id*. 227-229.

[23] *Id*. at 230-231.

[24] *Id*. at 245-247.

[25] *Id*. at 254-58.

[26] *Id*. at 159-160.

[27] *Id*. at 13.

[28] *Id*. at 12, 115-131.

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