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2017 Benefit and Payment Parameters Proposed Rule

OVERVIEW

On November 20th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule on benefit and payment parameters for benefit year 2017. Key provisions of the proposed rule would include modifications to payment parameters, network adequacy requirements, the Small Business Health Options Program, and the re-enrollment process for coverage purchased through the federal and state exchanges. The proposed rule would also create a new exchange model, the State-based Exchange on the Federal Platform, and introduce standardized plan options.

CMS will accept comments on the proposed rule until December 21st. This document summarizes several major provisions of the proposed rule, which is available here.

NETWORK ADEQUACY STANDARDS

Minimum Threshold

Provisions of the proposed rule would require states participating in the federal exchange to select a provider network adequacy standard. CMS will establish the minimum criteria for network adequacy standards at a later date.

The proposed rule would require:

- A quantitative network adequacy threshold to be selected by states. CMS anticipates that states would select among a certain number of metrics announced in the *Letter to Issuers*, which is anticipated to be released in early 2016; and
- A default time and distance standard to issuers applying for QHP certification in a federally-facilitated exchange (FFE), if a state does not select one of the applicable metrics.

CMS is interested in receiving comments on whether activities that improve transparency and network adequacy, such as indicating whether a plan has a broad number of doctors or facilities in their network, could improve the consumer experience in the future.

Continuity of Care

In the proposed rule, CMS would require two provisions regarding continuity of care applicable to QHPs on the FFE.

Provisions of the proposed rule would require the issuer to:

- Provide written notice to enrollees of discontinuation of a provider 30 days prior to the effective date of change or as soon as practicable; and
- Allow an affected enrollee to continue treatment until the treatment is complete or for 90 days at in-network cost sharing rates, in cases where a provider is terminated without cause.

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Cost Sharing

CMS proposes that issuers must count the cost sharing charged to an enrollee for certain out-of-network services that are provided at an in-network facility toward an enrollee's annual limitation of cost sharing. However, the enrollee may incur additional costs if the issuer provides 10 days' notification that an out-of-network provider may be providing these services.

STATE-BASED EXCHANGE ON THE FEDERAL PLATFORM MODEL

CMS proposes to create a new exchange model, the State-based Exchange on the Federal Platform (SBE-FP). The SBE-FP would allow state-based exchanges to implement certain processes using the federal eligibility and enrollment infrastructure.

Under the proposed rule, CMS would require states participating in the SBE-FP to enter into a platform agreement with the U.S. Department of Health and Human Services with a defined set of mutual obligations, including the scope of the federal services that the SBE-FP would use. The SBE-FP would retain the primary responsibility of ensuring marketplace requirements and performing marketplace functions such as plan management, consumer assistance, outreach functions, and ongoing oversight and program integrity. The SBE-FP may rely on the federal platform for activities such as eligibility determinations, enrollment processing, and consumer call center services.

Requirements that were previously only applicable to Qualified Health Plans (QHPs) offered on a FFE would also apply to QHPs offered on an SBE-FP. CMS proposes a user fee of 3 percent for QHPs offered through an SBE-FP to offset the cost of providing this infrastructure.

STANDARDIZED PLAN OPTIONS

Currently, standardized metal levels determine equivalent actuarial values, but not equivalent cost-sharing structures. CMS now proposes to designate plans with certain standardized cost-sharing structures as "standardized options." The proposed rule would create six standardized plan options, including a bronze plan, a gold plan, a standard silver plan, and three silver plans available for individuals eligible for cost-sharing reductions.

Under the proposed rule, it would be optional for issuers to offer standardized plan options, and issuers may offer non-standardized plans as well. An aim of the standardized plan option is to help consumers more easily compare plans offered by different issuers within a metal level.

RE-ENROLLMENT

CMS proposes that 2017 open enrollment will run from November 1, 2016 to January 31, 2017. The proposed rule also includes modifications to the re-enrollment process for the 2017 benefit year. Enrollees in a silver-level QHP that is no longer available for re-enrollment would be automatically re-enrolled in the most similar silver plan product offered by the same issuer, rather than a different metal level within the same product.

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CMS also requests comments on the automatic re-enrollment process when an enrollee's plan becomes substantially more expensive.

SMALL BUSINESS HEALTH OPTIONS PROGRAM

CMS proposes to increase options for employees in the federal Small Business Health Options Program (SHOP) for plan years beginning in 2017. CMS proposes to give employers the option to offer all plans across all levels of coverage from one insurance company. This proposal would be in addition to the current SHOP options, which allow employers to offer their employees either one health plan and/or one dental plan, or all health and dental plans across one metal level.

CMS seeks comment on whether a state with a federally-facilitated SHOP should have the opportunity to decide whether additional employee choice models should be made available in their state.

PAYMENT PARAMETERS

Among CMS's proposed modifications:

- **Federally-facilitated Exchange (FFE) User Fee:** CMS proposes to keep the 2017 FFE user fee rate of 3.5 percent for the fourth consecutive year;
- **Premium Adjustment Percentage:** CMS proposes a premium adjustment percentage of approximately 13.2 percent, covering the period from 2014 to 2017; and
- **Annual Limitation on Cost Sharing:** CMS proposes the 2017 maximum annual limitation on cost sharing would be $7,150 for individual coverage and $14,300 cumulative for family coverage.