Proposed HHS Notice of Benefit and Payment Parameters for 2018

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SUMMARY: Issues of Interest for State Regulators and Marketplace Officials

On August 29, The U.S. Department of Health and Human Services released its latest proposed Notice of Benefit Payment Parameters; the annual omnibus rule to put into place regulatory changes impacting the health insurance marketplaces for the next plan year. Notably, the proposal was released several months earlier than usual this year, likely as a means to finalize changes and gather input prior to a transition of the new Administration.

The proposal includes many provisions that could significantly impact health insurance markets as well as the State-based Marketplaces (SBMs) and the Federally Facilitated Marketplace (FFM). Specifically, changes aimed at addressing affordability and market stability, as well as opportunities for greater state flexibility, merit attention from state regulators and marketplace officials alike. Further details of these provisions are offered below.

Calling for Input on Future Innovation, Funding and Marketing

Fostering market-driven innovation: The Notice includes an open solicitation for how HHS can facilitate issuer, provider, marketplace, or local innovation in ways that contribute to better health outcomes and lower costs while creating differentiation for market participants. Combined with a recent Request for Information released by the Centers for Medicare and Medicaid Services in relation to the State Innovation Models Initiative[1], there are clear opportunities for states to provide feedback on the future direction of both coverage and care leading into the new Administration. This call may be of particular note especially for states seeking greater opportunity for innovation beyond what is currently allowed by the narrow restrictions of the 1332 innovation waivers.[2]

Establishing assessment fees; institutionalizing models that use federal systems: Leveraging flexibility and efficiency of available marketplace systems, several states have adopted elements of the federal marketplace while maintaining ownership of other marketplace functions. These include SBM states that have adopted the Federal Small Business Health Options Program marketplace (FF-SHOP) and states that have adopted the technology of the FFM for their individual marketplace, yet maintain outreach and plan management responsibilities (called SBM-FPs). The Notice proposes that SBMs that use the FF-SHOP adopt specific SHOP standards to ensure consistency with policies of the FF-SHOP (e.g., premium calculation, payment, and collection requirements, timelines for rate changes, employer contribution methodologies, open enrollment, coverage effective, and termination of coverage requirements).

The rule continues assessments on issuers to finance the FFM— states using the SBM-FP model will be required to pay a 3.0 percent assessment on issuers while issuers participating in the FFM will continue to pay a 3.5 percent assessment fee. The notice proposes that HHS will seek an exemption from requirements that user fees be sufficient to recover the full cost of the FFM.

Funding marketing and outreach: The Notice solicits comments on whether more funding should be allocated to outreach and education, including a suggestion to allocate a specific portion of the assessment fees for the FFM specifically to these activities. Marketing and outreach continues to play a key role in the strategies of the marketplaces to gain and maintain consumers, though the approaches for investment in this work have shifted over time. Drawing upon three years of data, marketplaces and their outreach and marketing partners now know more than ever about both marketplace consumers and the uninsured in their states. The solicitation is an important opportunity to affect how marketing and outreach efforts will be shaped and funded going forward.

Addressing Carrier Participation and Insurance Marketplace Stability

Stabilizing issuer risk in light of enrollee and utilization trends: Several provisions contained in the Notice aim directly to address challenges associated with issuer risk, mainly attributable to high-cost enrollees and the end of the transitional reinsurance program. This is an important and timely opportunity for states—most fresh from rate review—to provide input on whether these proposals will mitigate concerns over risk. See Table 1 for details of proposals. For example, evidence continues to mount regarding how prescription drugs, partial month enrollments, and high-cost utilizers impact issuer overall costs—all addressed by the proposed changes to risk adjustment. States may be able to provide additional evidence of the key factors impacting the stability of their issuers that may not be addressed by the Notice or that may influence the weight given to the solutions proposed within. Specifically, the Notice includes a request for more information regarding how misuse of special enrollment periods and eligibility verification processes impact continuity of coverage and risk pools—a key concern identified by several issuers and state regulators.[3]

Of particular note is a proposed changed to the rating system for children—the creation of a new age band for children from 0-14, with single-year bands proposed from ages 15-20. The change is aimed at mitigating large premium increases as children transition to adult coverage, but may impact affordability of coverage for families accessing coverage for children. The change may also produce some challenges for issuers and consumers that will need to make yearly adjustment over the proposed single-year rating span.

Issuer flexibility to encourage market entry and product innovation: A few proposed changes aim to ease issuer burden— eased restrictions on what triggers a market withdrawal, changes to medical loss ratio, reduction of data validation requirements for smaller issuers—subsequently encouraging participation and development of new product offerings. While some changes are minor, there may be some risk for abuse by issuers who leverage these loosened restrictions as a means to manipulate their product offerings in ways that could pose adverse impacts on consumers and markets. Regulators may wish to examine each change for its potential impact on markets, including how changes align or come into conflict with regulations governing individual and small group market products offered in each state.

Requirements to promote or maintain certain product offerings: The Notice clarifies a few requirements to assure more robust commitment and participation from issuers that opt to offer qualified health plans (QHPs). These proposals come in the midst of news of reduced market competition due to issuer exits—some which occurred in the middle of the coverage year. While designed to offer consumers additional protections and greater choice, the additional requirements could tax issuers in a way that may encumber their participation. States where issuers have mixed silver or gold offerings should take particular notice, evaluating whether enforcement of a requirement to offer both silver and gold-level plans in each service area would increase issuer offerings or drive any issuers to exit specific markets. States that operate in the FFM, should also take note of a proposal impacting issuer offerings on the FF-SHOP.

Table 1. Provisions that address carrier participation and insurance market stability

Stabilizing Issuer Risk	Issuer and Plan Flexibility	Issuer Responsibilities and Participation Requirements
• Adds risk adjustment rating factors to account for partial year enrollments, prescription drug use, high-cost enrollees and recipients of cost-sharing reductions • Calls for comment on how administrative costs (which may not be intrinsically linked to enrollee risk), should be reevaluated for the purposes of risk adjustment • Increases age rating ratios for individuals under 21 • Proposes creation of 7 new age bands applicable to individuals under the age of 21 • Codifies changes made to SEP programs made in January 2016[4]	• Adjusts medical loss ratio requirements to reduce potential adverse impacts on new entrants • Flexibility for issuers to adjust or shift products without triggering a market withdrawal • Widens the minimal variation of actuarial value allowed for bronze-level plans • Flexibility to reduce the burden of data validation for smaller issuers • Seeks information related to guaranteed issue in circumstances where issuers serve employers with employees in multiple geographic locations • Outlines processes for issuer appeals in cases of disputes over: QHP certification, cost-sharing reductions, and risk adjustment • Requests input on how essential community providers should be defined in the context of hospital operations	• Clarifies requirement that issuers offer at least one silver and one gold plan in each of their participating service areas • Requires that QHP issuers make plans available for the full year in which they are offered • Reevaluates whether certain FFM issuers should also be required to offer coverage in the FF-SHOP • Requires issuers to demonstrate appropriateness when rescinding coverage • Requires issuers to send notices to consumers when the issuer is denied certification • Asserts HHS authority to impose remedies when issuers are non-compliant with reviews

Allowing Flexibility to Align with State Systems and Policies

Having completed three open enrollment seasons, states and federal agencies continue to learn from, and subsequently, improve how marketplaces function. This is fueled by: an increased understanding of how marketplaces could and should interact with state and federal systems and policies; a growing collection of data on how consumers, assisters, issuers, and employers interact with the marketplaces in each state; and continued evolution of the technology underlying the marketplaces' portals. The Notice proposes several areas where states or state-based marketplaces may pursue new flexibilities in marketplace policies and operations, summarized in Table 2. Some, like flexibility on processes used for data matching and reconciliation, offer states greater opportunity to develop solutions to address what they have identified as ongoing areas of complication for their marketplaces. While the provisions identified in the Notice may not be applicable to all states or marketplaces, states may consider general support for flexibility to enable their ability to be proactive as systems and policies continue to develop.

Table 2. Provisions that allow flexibility to align with state systems and policies

Flexibility on state or marketplace policies	Flexibility on system operations

• Permits exchanges to develop alternative methods for recalculating advance premium tax credits (APTC) when eligibility redeterminations may change APTC
• Permits marketplaces to propose new processes to resolve data matching issues related to either income or non-income related circumstances
• Empowers marketplaces to extend issuer binder payment deadlines in response to technical errors.
• For purposes of risk adjustment calculations:
  • aligns the definition of large employer with what is codified in state law
  • offers states flexibility in defining merged market
  • seeks information on altering member month calculations to align with states that utilize family tiering
• Ensures that proposed FFM standard benefit designs do not conflict with state oral chemotherapy parity laws
	• Permanent extension of use of paper-based appeals processes
	• Broadens ability of marketplaces to use enrollment data from certain government programs when conducting eligibility
	• Amends the ACA to make electronic notices the default for SHOP; except as otherwise required by state or federal law or where paper notices are the preferred option of participating employers or consumers
	• Grants flexibility for individual and SHOP marketplaces to send paper notices when technological limitations prohibit electronic notices
	• Grants SBM-FP states choice on whether to have "differential display" of federal standardized plans

Standardizing Benefit Offerings; Improving Consumer Tools and Protections

Creation of four standard benefit offerings: Both state and federal marketplaces are evolving in accordance with changing consumer and market dynamics. The Notice addresses several issues specific to improving the consumer experience. Notably, it proposes changes to the standardized benefit offerings, also known as simple choice plans,[5] available through the FFM. First offered for the 2016-17 plan year, the plans are optional benefit designs issuers may adopt to enable consumers to make easier comparisons based on factors like premiums and plan networks. Changes include separation of medical and drug deductibles for gold and silver plans. Significantly, in an effort to meet demand for lower-cost options, the Notice proposes the addition of a bronze-level high-deductible health plan standard option that would allow consumers to qualify for a health savings account. States may consider commenting on the continued experimentation with standard designs as one strategy that may influence consumer choice and quality and affordability of products offered to their consumers.

Instituting consumer protections: The Notice also includes miscellaneous policies that may impact or institute protections for consumers; marketplaces and insurance departments may wish to examine how their execution may reverberate across issuers, consumers, and assisters (inclusive of brokers) if instituted. One proposal attempts to protect consumers from financial hardship that may be triggered when higher-than anticipated funds are automatically withdrawn from an individual's account as a result of adjustments made to the consumer's advance premium tax credits (APTC). Other proposals seek to clarify limited English proficiency (LEP) requirements, and an extension of surprise billing protection to off marketplace plans.

One issue of particular note is the attention brought to consumers that may dually qualify for Medicare and marketplace coverage. Current law does not prohibit renewal of marketplace coverage for someone who is Medicare eligible or mandate termination of marketplace coverage upon the event that a consumer becomes Medicare eligible. Per the Notice, states may consider providing feedback on how policies to require or prohibit marketplace renewal may impact costs for the consumers, market risk pools, and secondary payment requirements for Medicare or private market issuers.

Imposing new requirements on issuers and web-brokers conducting direct enrollment: The FFM has established partnerships with issuers and web-brokers[6] that wish to serve marketplace consumers. Web-brokers and issuers present an opportunity to expand the capacity of marketplaces to reach consumers, especially where issuers or brokers have established reputations with local communities. The Notice includes several provisions to ensure that these entities are equipped with appropriate tools to serve consumers through eligibility and enrollment in a marketplace QHP. The Notice also outlines an "enhanced direct enrollment pathway" for FFM web-brokers and issuers to simplify enrollment for consumers that utilize these entities. The exact nature of how these entities could or should interact with marketplaces is still developing. Recognizing the potential risks in connecting with third-party partners, the Notice solicits comments on how these provisions may impact consumer privacy and data security. Additionally, states may wish to comment on other protections or regulations that should be considered to ensure that these entities optimally serve consumers in the acquisition of affordable, quality coverage as vehicles supporting the marketplaces.

Table 3. Provisions relating to benefit design and consumer tools and protection		
Benefit design	**Consumer protections**	**Agent/Broker Programs Direct Enrollment Pathway**

• Establishes three new sets of standard benefit options for the FFM and SBM-FP states
• Establishes an additional high-deductible standardized health plan option
• Proposes indicators to be used for plans that use integrated delivery systems
	• Clarifies which entities are able to aggregate LEP populations across geographic areas for the purposes of creating language tags
	• Proposes alteration or elimination of LEP requirements to align better with existing laws
	• Proposes a safeguard policy for consumer to protect from higher-than-expected account withdrawals in cases where APTC has been adjusted
	• Extends surprise billing protections to off-marketplace plans
	• Seeks clarity on policies impacting marketplaces individuals that qualify for Medicare
		• Proposes an enhanced direct enrollment pathway through which consumers would submit eligibility information directly on the website of issuers or web-brokers (instead of being redirected to healthcare.gov)
		• Specifies new requirements for issuers and brokers conducting direct enrollment including:
		  • differential display of HHS designated plans
		  • standards for operational readiness
		  • provision of specific consumer tools and content
		  • post-enrollment engagement with consumers
		• Proposes new oversight requirements for agents and brokers

Modifying SHOP enrollment requirements

Since opening, the majority of SHOP marketplaces have only seen limited participation, with some states utilizing 1332 waivers to request full elimination of SHOP.[7] The Notice proposes removing all enrollment functionality from the FF-SHOP, and seeks input as to whether SBMs should be given the same option for their SHOP. The change would render SHOP effectively into just a website, with alternate structures put in place for enrollment (web-brokers or third party administrators are suggested for a possible role in this). The change would permit marketplaces to devote resources away from the sluggish program toward more fruitful investments. However, states with successful SHOPs may wish to advocate for flexibility in allowing states to decide individually what model of SHOP they would prefer. Beyond this significant proposed change, the Notice also includes changes to guarantee 30-day enrollment periods for any new employees coming into SHOP.

Final comments are due to HHS by October 6 at 5pm.

Endnotes

1. Centers for Medicare and Medicaid Services. "Next Steps for the State Innovation Models Initiative Request for Information," September 8, 2016. Accessed on September 27, 2016. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-09-08-2.html
2. Heather Howard and Dan Meuse. "New Section 1332 Guidance a Mixed Bag for States." Health Affairs Blog, February 29, 2016. Accessed on September 27, 2016. http://healthaffairs.org/blog/2016/02/29/new-section-1332-guidance-a-mixed-bag-for-states/
3. Robert Pear. "Insurers Say Costs are Climbing as More Enroll Past Health Act Deadline." The New York Times, January 9, 2016. Accessed on September 27, 2016. http://www.nytimes.com/2016/01/10/us/politics/insurers-say-costs-are-climbing-as-more-enroll-past-health-act-deadline.html?_r=0
4. Timothy Jost. "After Insurer Complaints, Small Steps to Toughen Special Enrollment Period Eligibility." Health Affairs Blog, January 20, 2016 Accessed on September 27, 2016. http://healthaffairs.org/blog/2016/01/20/after-insurer-complaints-small-steps-to-toughen-special-enrollment-period-eligibility/
5. Kevin Counihan, Patrick Conway, "Simplifying Choices in the Marketplace-Simple Choice Plans and Quality Star Ratings." The CMS Blog, April 29, 2016, Accessed on September 27, 2016 https://blog.cms.gov/2016/04/29/simplifying-choices-in-the-marketplace-simple-choice-plans-and-quality-star-ratings/
6. Nearly 60 web-brokers signed agreements to work with the FFM as of July 2016. Centers for Medicare and Medicaid Services. "Centers for Medicare and Medicaid Services Web-broker Public List: July 2016 Edition." Accessed on September 27, 2016 https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/July_Public_2016_WBE_List_.pdf
7. Emily Curran, Sabrina Colette, Kevin Lucia, "State-run SHOPs: An Update three Years Post ACA Implementation." The Commonwealth Fund, July 29, 2016 Accessed September 27, 2016 http://www.commonwealthfund.org/publications/blog/2016/jul/state-run-shops