NAVIGATING HEALTHCARE REFORM

March, 2016

ACA In The News: 2017 Benefit and Payment Parameters

OVERVIEW

On February 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. This rule also incorporates new definitions of large employer and small employer consistent with the Protecting Affordable Coverage for Employees (PACE) Act.

ANNUAL LIMITS ON COST SHARING

Effective for plan years beginning on or after January 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. 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

Prior to January 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 October 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.

MARKETPLACE 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 November 1 of the preceding year, and ending on January 31 of the benefit year.

As a result:

- The 2017 open enrollment period will begin on November 1, 2016, and run through January 31, 2017.
- The 2018 open enrollment period will begin on November 1, 2017, and run through January 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 November 1 and run through December 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.

Consumers shopping for health insurance coverage on the federally-facilitated Exchange (FFE) will now have six "standardized" benefit plan options as a result of the rule. The standardized benefit plans will simplify plan selection by allowing consumers to more easily compare plans across issuers in the FFE. The standardized options will include one bronze option, one silver option, a separate standardized option for each silver plan variation (73%, 87%, and 94%) available to individuals who are eligible for cost-sharing reductions, and one gold 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 essential health benefits that compromise a large percentage of the total allowable costs for an average enrolled. Issuers are not required to offer standardized options in 2017. HHS is currently conducting consumer testing to determine how these plans will be displayed on the Exchange.

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.