Proposed Benefit Payment and Parameters Rule Released

Federal agencies have released the proposed rule for the 2017 Benefit Payment and Parameters. Among other items, it provides updates and annual provisions relating to:

- Risk adjustments, reinsurance, and risk corridors programs
- Cost-sharing parameters and cost-sharing reductions
- User fees for Federally-Facilitated Exchanges (FFEs)
- The standards for open enrollment for the individual market for the 2017 benefit year
- Updates to the Small Business Health Options Program (SHOP)
- Definitions of large and small employer
- Guaranteed availability
- Medical loss ratio (MLR) program

The Benefit Payment and Parameters rule is typically finalized in the first quarter of the year following the release of the proposed version. Comments on the proposed rule are due by December 21, 2015.

The proposed rule would set cost sharing for the 2017 calendar year for self-only coverage at $7,150 and $14,300 for other than self-only coverage. The 2017 open enrollment period would be from November 1, 2016, to January 31, 2017.

The proposed rule suggests amending the regulatory definitions of “large” and “small” employers to match the definition set by the Protecting Affordable Coverage for Employees Act (PACE Act). The definitions would be revised to define a large employer as one that averages at least 51 employees in the previous year, but states may elect to define large employers as those with 101 or more employees. Similarly, the definition of small employer would change to an employer with an average of at least 1 but not more than 50 employees on business days during the preceding calendar year. States may elect to define a small employer as one with 100 or fewer employees. The rule would also provide that, for an employer not in existence the preceding calendar year, its size should be determined by its reasonable expectation of the average number of employees during the year.

The proposed rule would amend the rules relating to the rating area for a small group plan, which is currently the group policyholder’s principal business address. The proposed rule would provide that, if an

employer has registered an in-state principal business address with the state, that address would be the principal business address. If that address is not a substantial worksite for the employer, the employer would designate as its principal business address the business address where the greatest number of employees work in the applicable state.

The Patient Protection and Affordable Care Act (ACA) provides for guaranteed availability of coverage. In 2014, regulations provided that small employers could not be denied coverage for failure to satisfy minimum participation requirements, but that insurers could limit the availability of coverage to small employers not meeting contribution or participation rules to an annual enrollment period of November 15 to December 15 of each year. Federal agencies are now concerned that the limitation of enrollment to that time frame can result in applicable large employers avoiding shared responsibility payment because they cannot offer coverage in states where the small group market is expanded to employers with up to 100 employees. The proposed rule would prohibit carriers in those states from restricting availability of small group coverage based on employer contribution or group participation rules.

The proposed rule establishes standards of conduct for agents and brokers that assist consumers to enroll in coverage through FFEs and to protect consumers and ensure the proper administration of the FFEs. Violations of these standards would result in termination for cause of the agent's or broker's agreements with the FFEs. Similarly, the proposed rule would provide that agents or brokers who enroll qualified individuals, employers, or employees in coverage that constitutes enrollment through a state-based Exchange on a federal platform (SBE-FP) or assists individual consumers with submission of applications for Exchange financial assistance through an SBE-FP must comply with all of the FFE standards.

Federal agencies are seeking comment generally on special enrollment periods, due to concerns that they may be subject to abuse. The rule would allow Exchanges to terminate (including retroactively) coverage if the enrollment was due to fraudulent activity.

The proposed rule would also require notification of an employer if an employee enrolls in a qualified health plan on the Exchange, not upon determination of eligibility. This allows the employer to appeal the employee's eligibility.

The proposed rule would give the Exchanges more operational flexibility when implementing an employer appeal decision. Currently, if an employer appeals a decision and it affects an employee's eligibility, the Exchange must re-determine the employee's eligibility and the eligibility of the employee's household members. This can happen when an employer prevails in establishing that it offers employer-sponsored coverage that is affordable and meets minimum value standards, which renders the employee not eligible for a subsidy.

Beginning in 2017, federal agencies would propose adding a "vertical choice" option for qualified health plans and stand-alone dental plans under which employer can offer qualified employees a choice of plans across all levels in the SHOP. This would provide multiple plan options to an employer. The proposed rule would also require the first premium payment on the SHOP be made on or before the 20th day of the month prior to the month in which coverage begins, which is five additional days beyond the current recommendation of the 15th of the month. The proposed rule would also require employers to use a "fixed contribution strategy" for SHOP plan when they offer a single plan to qualified employees.

The proposed rule would update the definition of “large employer” and “small employer” in the MLR regulations to match those previously determined by the PACE Act. The rule would also amend the definition of unpaid claims reserves relating to the MLR and use a six-month, rather than a three-month, run-out period beginning with the 2015 reporting year.

Federal agencies also published the proposed 2017 actuarial value calculator and its methodology.

11/24/2015