2017 Notice of Benefit and Payment Parameters

On November 20, 2015, the Centers for Medicare and Medicaid released the Proposed Notice of Benefit and Payment Parameters (NBPP) for the 2017 plan year. The NBPP proposes rules on exchange plans, as well as provides some guidance on individual, small group, and large group markets. Many of the proposed changes in the 2017 NBPP seek to ease issues related to consumer enrollment and access to coverage. Below are the relevant NBPP provisions organized as how they relate to NHC’s five key principles for a patient-centered Marketplace. Comments on the proposed rule are due on December 21, 2015.

Non-discrimination. Confirm plan designs do not discriminate or impede access to care, including a provider network that ensures patients can access care when they need it.

Unfortunately, this rule does not prohibit plan designs that discriminate against people with chronic conditions through formularies and cost sharing. However, there are provisions that help prevent discrimination in other ways:

- Prescription Drug Benefits (§156.122) – Health and Human Services (HHS) reviews the exceptions process for obtaining non-formulary drugs, and clarifies that the exceptions process and the appeals process in §147.136 are two distinct processes that will not change. However, HHS is considering changes to the exceptions process to allow a State’s more stringent coverage appeals law or regulations to satisfy the requirements of Section §156.122(c). HHS is also considering amending the exceptions process to allow for a second internal review of 72 hours for standard requests and 24 hours for expedited requests.

- Minimum Thresholds for Network Adequacy (§156.230(D)) – HHS proposes that Federally-Facilitated Exchanges (FFE) would rely on State reviews for network adequacy. States would be required to select an acceptable quantifiable network adequacy metric, subject to certain minimum criteria established by HHS. In states that do not conduct reviews, a Federal default time and distance standard would be used. For the certification cycle for plan year 2017, HHS plans to review the number and types of providers at the county level, using standards similar to those in Medicare Advantage, focusing on the most-commonly used specialties by enrollees. The county-specific time and distance parameters would be detailed annually in the Letter to Issuers.
Transparency. Provide access to clear and accurate information for consumers about covered services and costs in exchange plans, including a user-friendly exchange website.

- Standards Applicable to Navigators and Non-Navigator Assistance Personnel (§155.210; §155.215; §155.225) – HHS proposes to require Navigators in all exchanges to provide targeted assistance to underserved and/or vulnerable populations within an exchange’s service area. HHS proposes to expand duties of Navigators to include specific post-enrollment and other assistance activities. HHS proposes to require certified application counselor (CAC) organizations to provide the exchange they service with metrics on the number of CACs inside the organization and their performance. HHS clarifies that gifts should not be provided to applicants and potential enrollees.

- Actuarial Value (AV) Calculation for Determining Level of Coverage (§156.135) – HHS proposes to update the AV calculator annually for material changes and proposes to establish specific timelines and materiality thresholds for updates to the continuance tables.

- Out-of-network Cost Sharing (§156.230 (F)) – HHS proposes requiring Qualified Health Plans (QHP) issuers to count cost-sharing for an Essential Health Benefit (EHB) by an out-of-network provider in an in-network setting towards the enrollee’s maximum out-of-pocket limit. HHS is also soliciting feedback on other issues including adding wait times to network standards; surveying providers to determine if they are accepting new patients; and whether to require issuers to offer transparency when designing provider networks.

- Other Notices (§156.1256) – HHS proposes to require issuers to notify enrollees within 30 days if a plan or benefit display has an error. Issuers would also have to notify enrollees of the availability of a Special Enrollment Period (SEP).

Federal and State Oversight. Ensure all exchange plans meet applicable state and federal requirements, including the state's plan management and rate review.

- Rate Review and Rate Justification (§154.200 and §154.215) – HHS proposes to subject a plan to review, after January 1, 2017, if a rate increase for all enrollees weighted by premium volume for any plan within the product meets or exceeds the applicable threshold. HHS also proposes to require all issuers to submit the Unified Rate Review Template for all single risk pool coverage products in the individual or small group market.

- Essential Health Benefits (§155.170) – HHS specifies that a benefit required by the state on or before December 31, 2011 is considered an EHB. Benefits required by the state after December 31, 2011 that apply to QHPs are not considered EHB unless enacted in compliance with federal requirements. HHS proposes to designate the state, rather than the exchange, as the deciding entity on which state-required benefits are in addition to the EHB, as well as the entity that receives issuer calculations on costs attributed to state-required benefits. HHS clarifies that new requirements related to habilitative services in the 2016 NBPP must be met in order to be deemed EHB-compliant. HHS also clarifies
that state benefit mandates for the large group market would not be considered EHBs for QHPs in individual and small group markets.

- Standards for HHS-Approved Vendors of FFE Training for Agents and Brokers (§155.222) – HHS proposes to eliminate requirements that HHS-approved vendors of FFE training for agents and brokers perform information verification functions.

- Meaningful Difference Standard for QHPs in the FFEs (§156.298) – HHS proposes to modify the criteria that deem a plan meaningfully different due solely to health savings account eligibility.

- Eligibility and Enrollment Standards for Qualified Health Plan Issuers on State-Based Exchanges which are Using the Federal Platform (§156.350) – HHS proposes to require any issuer participating in a State Based Exchange using the Federal Platform(SBE-FP) to adhere to HHS regulations and guidance related to eligibility and enrollment functions. SBE-FPs would also have to administer their SEPs within the guidance of FFEs.

- Enforcement Remedies in FFEs (§156.805; §156.810; §156.815) – HHS clarifies issuer’s right to file a request for a hearing on the assessment of a civil money penalty. HHS proposed new bases for decertification of a QHP issuer.

- Establishment of Patient Safety Standards for QHP Issuers (§156.1110) – HHS proposes new specifications to strengthen patient safety standards. HHS proposes to require issuers that contract with hospitals with 50 or more beds to verify the hospital uses a patient safety evaluation system, ensure the hospital has a comprehensive discharge program, and implements evidence-based initiatives to reduce all-cause preventable harm, prevent readmission, improve care coordination, and improve quality.

**Uniformity.** Create standards to make it easier for patients to compare exchange plans, such as a quality scorecard and standardized plan materials.

- Optional Standardized Benefit Design (§156.20) – In order to simplify the consumer shopping experience, HHS proposes to establish “standardized options” consisting of standardized cost sharing for a key set of EHB in the individual market FFEs. Issuers would not be required to offer standardized options, and would still be able to offer non-standardized plans. HHS is exploring ways to display standardized options on HealthCare.gov that makes it easier for consumers to find.

- Direct Enrollment in Exchange Coverage through an Issuer or Web-Broker (§155.220; §156.265) – HHS proposes to allow applicants to apply and enroll in coverage through the website of an issuer or web-broker. HHS proposes additional standards and penalties for certified agents or brokers who are involved in fraud or abusive conduct.
• Annual Open Enrollment Period (§155.410) – The 2017 open enrollment period will remain the same as the 2016 open enrollment period, beginning on November 1, 2016 through January 31, 2017. HHS is also proposing the 2018 open enrollment period with two alternatives: begin the period earlier with the same amount of time, possibly from October 15, 2017 to January 15, 2018; or begin earlier and have a shortened time period, lasting from October 15, 2017 to December 15, 2017.

Continuity of Care. Broaden sources of coverage and protect patients transitioning between plans, including expanded Medicaid.

• Treatment of Guaranteed Availability when a Plan is Discontinuing the Coverage (§146.150 and §147.104) – HHS proposes to add an exception to guaranteed availability and renewability to allow an issuer that decides to discontinue a product or all coverage to deny enrollment in such coverage after releasing the discontinuation notice. HHS clarifies that this exception does not relieve issuers of responsibility to existing policyholders.

• Auto Enrollment Hierarchies (§155.335) – HHS is seeking comment on whether to amend the current auto reenrollment hierarchy.

• Provider Transitions (§156.230(E)) – HHS proposes two new requirements for provider network changes 1) considering requiring all QHP issuers in FFEs to notify enrollees 30 days prior to discontinuation of a provider and 2) if a provider is terminated without cause, QHP issuers would be required to allow patients active treatment for 90 days at in-network cost.

• Essential Community Providers (ECPs) (§156.235) – HHS seeks comment on whether multiple contracted or employed full-time equivalent practitioners at a single location should toward both the available ECPs in the plan’s service and satisfy the issuer’s essential community provider participation.

• Individual Exchange Coverage Effectuation and Grace Period (§156.270) – HHS proposes to allow individuals to remain in coverage and receive a 3 month grace period if they fail to pay the January premium in full.

• Acceptance of Certain Third Party Payments (§156.1250) – HHS aims to clarify which government entities may administer premium and cost-sharing assistance through grantees or sub-grantees. HHS proposes to require issuers to accept third-party cost-sharing payments in addition to premium payments. HHS is considering accepting third-party payments from all non-profit charities.