On March 8, 2016 HHS published its Final Notice of Benefit and Payment Parameters for 2017.¹ The Notice contains rules and parameters that would apply to the individual and small group health insurance markets in 2017, and modifications to previously promulgated rules. This document represents a summary of our interpretation of the Notice but does not constitute, nor is it a substitute for, legal advice.

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A. REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

Definitions (§144.103)

- Plan year continues to be defined as in §144.103, however the Notice confirms that in no instance could a plan year be defined as longer than 12 months
- The regulatory definition of small employer and large employer are revised effective January 1, 2016 to be consistent with amendments made as a result of the PACE Act
  - A small employer is defined as an employer who employed at least 1 but not more than 50 employees on business days during the preceding calendar year, and employs at least 1 employee on the first day of the plan year
  - A large employer is defined as an employer who employed an average of at least 51 employees on business days during the preceding calendar year, and employs at least 1 employee on the first day of the plan year
  - States are allowed to elect to expand the definition of small employer up to 100 (i.e., substitute “50” with “100” and “51” with “101” in the definitions above)

B. REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

- The Department of Health and Human Services (HHS) makes exceptions to the small group guarantee renewability requirement when discontinuing a product or all coverage in a market (see Section C.2 below)

C. HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

1. Fair Health Insurance Premiums (§147.102)

- The rating area applicable to a small group is based on the employer’s in-state principal business address
  - If an in-state principal business address is not registered or is not a substantial worksite for the employer, the principal business address is the one with the most employees
- If a network plan with a limited service area needs to make a plan available to an employer outside its service area because the employer has one or more employees that live, work or reside within its service area, an additional principal business address is allowed to be identified as the business address within the plan’s service area where the greatest number of employees work as of the beginning of the plan year (HHS would not be able to accommodate this on FF-SHOPs)
  - If there is no such business address, the rating area for purposes of the network plan is the rating area where the greatest number of employees within the plan’s service area live or reside as of the beginning of the year

2. Guaranteed Availability of Coverage (§147.103)

- The Notice enforces the guaranteed availability requirements in cases of product discontinuance or market withdrawal
- States electing to expand the definition of small employer to include employers with up to 100 employees may opt to prohibit small group health insurance issuers from restricting the availability of small group coverage based on employer contribution or group participation rules

3. Guaranteed Renewability of Coverage (§147.106)

- HHS confirms its position to allow the following exceptions to guaranteed renewability of coverage
  - The ability to non-renew coverage when a group plan sponsor has violated a material plan provision related to employer contribution or group participation rules
  - The ability to non-renew coverage when an individual’s or group’s coverage is through a bona fide association and their association membership ends
4. Student Health Insurance Coverage (§147.145)
   • Student health insurance coverage continues to be considered a type of individual coverage
   • Issuers may continue to utilize a separate single risk pool for student health coverage
     – Separate risk pools may be maintained for each institution and multiple risk pools may be maintained
       within a single institution as long as they are based on a bona fide school related classification (e.g.,
       undergraduate vs. graduate students) and not based on health status
     – Risk pools may include enrollees at more than one institution within a state or nationally
     – Separate risk pools may be established for students and dependents as long as dependents are enrolled
       in separate coverage (If students and dependents are enrolled in the same coverage rates for the risk
       pool may vary based only on age and family size)
   • Adjustments to rates within a risk pool must be actuarially justified
     – Rating factors such as the percentage of students enrolled in coverage or the length of time the college
       or university has had coverage through the issuer are prohibited
   • Student health plans are exempt from requirements to offer plans only at the specified metal levels effective
     with policy years beginning July 1, 2016
     – Plans are instead required to offer coverage with an actuarial value of at least 60%
     – The actuarial value must be determined using the actuarial value calculator
     – The student health insurance issuer must disclose the actuarial value of the coverage and the metal level
       the coverage would satisfy; if the plan does not fall within a metal level the issuer is to disclose the next
       lowest metal level
   • HHS will continue to monitor whether factors are being used to develop rates for student health insurance
     coverage that are not actuarially justified

D. STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT

1. Sequestration
   • Reinsurance payments made from fiscal year 2016 receipts will be sequestered at a rate of 6.8%
   • Risk adjustment payments made during fiscal year 2016 will be sequestered at a rate of 7.0% in all states
     where HHS operates risk adjustment
   • Funds that are sequestered in fiscal year 2016 will be made available in fiscal year 2017 without further
     Congressional action

   • The overall risk adjustment methodology and the payment transfer formula will not change for 2017
   • HHS will recalibrate the 2017 risk adjustment model using 2012, 2013 and 2014 MarketScan data
     – The model coefficients will be developed independently for each of the three years of MarketScan
       data, with the factors used in the model representing a blend of the coefficients over the three
       year period
     – This method allows for greater transparency and ease in updating for future calibrations
     – The 2017 risk adjustment model will not be implemented retroactively to calculate 2016 risk scores
     – The 2016 risk adjustment model will be used to calculate 2016 risk scores
     – HHS has incorporated differential trends into the development of the risk adjustment factors in 2017,
       using different trends for traditional drugs, specialty drugs, and medical and surgical expenditures
• HHS included preventive services covered at 100% in the simulation of plan liability when recalibrating the risk adjustment model for 2017
  - Preventive procedures were identified in the 2012 and 2013 MarketScan data using procedure and diagnosis codes, prescription drug therapeutic classes, and enrollee age and gender
  - Adjusting for preventive services has the following effects:
    - Age-gender coefficients increase relative to HCC coefficients, especially in the higher cost sharing Bronze and Silver metal levels, and in age/sex ranges with high preventive services, e.g., young adult females
    - Risk scores of healthy enrollees increased relative to the risk scores of less healthy enrollees, especially in Bronze and Silver metal levels

• HHS made no changes to the HCC categories used in the model for the 2017 benefit year
• HHS is investigating how prescription drug data could be included in the Federally certified risk adjustment model to improve the predictive power of the model without incentivizing altered prescribing patterns, and is also considering how to treat partial year enrollees
• HHS will operate risk adjustment in all states, including Massachusetts, for the 2017 benefit year
• The risk adjustment user fee will be $1.56 per enrollee per year, or $0.13 PMPM, compared to $1.75 per enrollee per year in 2016

3. Provisions and Parameters for the Transitional Reinsurance Program (§153.405(i))
• Any excess contributions for reinsurance payments for 2016 will be used to increase the coinsurance from 50% up to 100%, and if any contributions remain, the 2016 attachment point of $90,000 will be reduced to the point where all remaining funds are paid
• Contributing entities are responsible for ensuring that an entity assisting the contributing entity with the administration of its obligations under the reinsurance program cooperate with any audit

4. Provisions for the Temporary Risk Corridors Program (§§153.510(g) and 153.530)
• HHS will make the following adjustments to the 2015 MLR and Risk Corridors Annual reporting
  - As a program integrity measure, and to discourage plans from submitting certified estimates of cost sharing reduction (CSR) amounts that are lower than the actual CSR amounts provided, the full difference between the certified estimate included in the 2014 reporting and the actual CSR payments for 2014 will be subtracted from 2015 benefit year risk corridors payment or added to the charge
  - The risk corridors calculation for 2015 and 2016 must reflect a true-up of unpaid claims estimates in 2014 and 2015 using paid claims through June 30 of the following benefit year
  - CMS will address the true-up for 2016 experience after having evaluated the results of the true-up for 2014

5. Distributed Data Collection for the HHS-Operated Programs

Interim Dedicated Distributed Data Environment Reports (§153.710(d))
• HHS is eliminating the requirement that an issuer notify HHS of any discrepancy it identifies between the data provided on the EDGE server and the interim dedicated distributed data environment report due to the administrative burden for both issuers and HHS
• HHS plans to release an interim summary report sometime in March 2016 for those states and risk pools where the risk adjustment data has been submitted by February 1, 2016 and where the data meets HHS’s data sufficiency threshold. The interim reports will include the following: 1) average monthly premiums, 2) average plan liability risk score, 3) average allowable rating factor, 4) average actuarial value, 5) billable member months, and 6) geographic cost factors. HHS will also provide issuers with their own, issuer-specific data
  - HHS cautions that these reports will be preliminary and subject to change
Evaluation of Quality and Quantity of EDGE Data Submissions (§153.710(f))

- HHS will measure data quantity by comparing an issuer’s self-reported baseline total enrollment and claim counts by market to data submitted to the issuer’s dedicated distributed data environment. Issuers with enrollment counts lower than its baseline data will be assessed the default risk adjustment charge if the default charge is lower than the charge it would have received through the risk transfer calculation.

- Issuers that do not meet data quality standards will be assessed the default risk adjustment charge and may forfeit their reinsurance payments, with data quality measured using an outlier analysis:
  - Data quality metrics must be provided annually; the 2015 benefit year metrics will be:
    - Percentage of all enrollees with at least one HCC
    - Average number of conditions per enrollee with at least one HCC
    - Issuer average risk score
    - Average number of diagnosis codes per medical claim
    - Average premium per member per month
    - Percentage of individual market enrollees with reinsurance payments
    - Average reinsurance payment per enrollee for which the issuer would receive reinsurance payments
    - Claims per enrollee ratio
    - Percent of enrollees without claims
    - Percent of medical claims that are institutional claims
    - Percent of claims that are pharmacy claims
  - These data quality checks would be performed after April 30 of the year following the benefit year, the deadline submission date.
  - Issuers will have 10 days from the date of being notified that their data submission fails HHS’s quality thresholds to submit an explanation for HHS’s consideration to avoid being assessed the default risk adjustment charge.

Data Requirements (§153.710(g))

- CSR amounts must be reported in the MLR and Risk Corridors Annual Report regardless of whether a request for reconsideration has been submitted.

- Changes to risk adjustment payments or charges, reinsurance payments, or CSR payments must be reported in the next MLR and Risk Corridors Annual Report; if known during an open MLR and risk corridors period, the modified amounts must be reported in that open reporting cycle.

- HHS has given itself the authority to modify MLR and risk corridors reporting through guidance.

- Adjustments reported by CMS to plans by August 15 must be reported in the current reporting cycle.

Good Faith Safe Harbor

- HHS has confirmed that starting in CY2016 issuers may be subjected to a civil monetary penalty (CMP) for failure to comply with the HHS-operated risk adjustment and reinsurance data requirements in a timely manner, even if that failure relates to benefit year 2015.

Default Risk Adjustment Charge (§153.740(b))

- HHS is changing the default risk adjustment charge that will be imposed if an issuer does not establish a dedicated distributed data environment or does not provide adequate risk adjustment data:
  - For the 2015 plan year, the charge will increase from being calculated at the 75th percentile to being calculated at the 90th percentile.
  - For the 2016 plan year, issuers with 500 or fewer statewide billable member months in the individual and small group markets combined will be subject to a default risk charge equal to 14% of premium, which was calculated as the mean charge paid by issuers with 500 or fewer member months in 2014.
• Issuers, or state guarantee funds or liquidators, that acquire or enter into an arrangement to serve the current enrollees of another issuer with substantially the same terms may accrue the previous months of claims experience for purposes of risk adjustment

E. HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS


Rate Increases Subject to Review (§154.200)
• Starting in 2017, a rate increase for a single risk pool is subject to review if the premium weighted average increase, when including changes in premium rating factors, for all enrollees for any plan exceeds the applicable threshold
  - HHS previously indicated the metric used would be the plan adjusted index rate, but has recognized changes to the plan adjusted index rate would not reflect changes to the geographic, age, family size, and tobacco factors

Submission of Rate Filing Justification (§154.215)
• Issuers are required to submit a Unified Rate Review Template for all single risk pool filings, regardless of whether any plan within a product is subject to a rate increase
• Issuers are required to submit a Part III Actuarial Memorandum for all single risk pool filings where at least one plan within a product is subject to a rate increase
• Student health insurance plans will continue to use the prior Rate Review Justification module of the Health Insurance Oversight System (HIOS)

Submission and Posting of Final Justifications for Unreasonable Rate Increases (§154.230)
• HHS will make available on its website Part I and Part III non-trade secret portions of each rate filing justification for all proposed rate filings
  - Currently, information is only made available for proposed rate increases subject to review, and final rate increases
• HHS set the following deadlines for rate submission
  - Issuers in a state with an effective rate review program must submit rate filings for single risk pool coverage on a date set by the State, so long as the date is not later than July 15, 2016
  - Issuers in a state without an effective rate review program must submit rate filings for single risk pool coverage on a date set by the State, so long as the date is not later than May 11, 2016
• States with effective rate review programs may set a uniform date to post proposed rate filings for single risk pool products with rate increases subject to review, so long as the date is not later than August 1, 2016
• Final rate increase information for all single risk pool coverage must be posted at a uniform time by the first day of open enrollment

F. EXCHANGE ESTABLISHMENT STANDARDS

1. General Provisions (§155.20)
• The definition of an “applicant” has been amended to include an employer who is seeking eligibility to purchase coverage through the SHOP, even if the employer is not seeking to enroll in coverage themselves
• HHS has defined a “Federal platform agreement” as one between a State Exchange and HHS under which certain Exchange functions will be carried out on the Federal platform
  - State based Exchanges using the Federal platform will be known as an SBE-FP
  - State election to implement the SBE-FP will occur through the Blueprint process outlined in §155.106(c)
• The definition of a small employer and large employer has been amended to conform with the recently passed PACE Act
2. General Standards Related to the Establishment of an Exchange

Election to Operate an Exchange after 2014 (§155.106)

- HHS will provide technical assistance and initiate transition planning following submission of a declaration letter by a state, so that key milestones can be achieved and deadlines met, prior to the Blueprint application process
  - States must submit declaration letters approximately 21 months prior to the beginning of a state based Exchange’s (SBE’s) first annual open enrollment and approximately nine months prior to an SBE-FP’s first annual open enrollment
  - States planning to establish a SBE must submit a Blueprint at least 15 months prior, and the blueprint must be approved or conditionally approved at least 14 months prior to the date the Exchange proposes to begin open enrollment as a SBE
  - States planning to establish an SBE-FP must submit a Blueprint at least three months prior, and the Blueprint and operational readiness assessment must be approved or conditionally approved at least two months prior to the date the Exchange proposes to begin open enrollment as an SBE-FP
- Prior to approval or conditional approval of the Blueprint a State must execute a Federal platform agreement for utilizing the Federal platform for select functions

Additional Required Benefits (§155.170)

- HHS clarified that even though new benchmark plans selected by states for 2017 cover state mandated benefits that were enacted after December 31, 2011, these benefits must continue to be considered non-EHB benefits and the State must continue to defray the cost of those benefits
  - Going forward the State, rather than the Exchange, must identify which additional State-required benefits are not EHB, and issuers must submit the cost of such benefits to the State rather than the Exchange
  - The exception is if the benchmark plan is a large group plan that includes a mandated benefit that applies only to large groups; in this case the State would not be required to defray the cost of the benefit as the issuer has the option to substitute another benefit for the mandated large group benefit
- States expanding the definition of small employer to include groups size 1 to 100 must make all plans available to all small employers, and therefore the State must defray the additional cost of all State mandated benefits enacted after December 31, 2011, even if the mandate only applies to some groups meeting the definition of a small employer

3. General Functions of an Exchange

Functions of an Exchange (§155.200)

- Under an SBE-FP the Federal government will perform functions related to eligibility and enrollment, perform certain call center functions and casework processes, and maintain related information technology infrastructure; the SBE-FP will retain responsibility for plan management functions and consumer support functions, subject to certain FFE standards
  - A Federal platform agreement between the State and HHS will indicate the applicable markets and specify the services covered and the corresponding user fees (note that the services the Federal government provides to a SBE-FP will be fixed, i.e., there will not be a menu of services from which the SBE-FP can select)
  - State oversight under a SBE-FP must include requirements that are no less strict than those applicable to QHPs and QHP issuers on an FFE; when the SBE-FP is not enforcing one or more of the requirements applicable to QHPs and QHP issuers on an FFE, HHS will have the authority to suppress a plan
  - SBE-FPs are not required to operate a toll-free call center, but must instead operate a toll-free hotline to respond to requests for assistance from consumers in their state
  - SBE-FPs must operate an informational website that at a minimum directs consumers to HealthCare.gov
• HHS will have the authority to oversee and monitor SBE-FP compliance with privacy and security standards established and implemented by an FFE

Consumer Assistance Tools and Programs of an Exchange (§155.205)
• An SBE-FP will not be required to operate a toll-free call center but would be required to operate a toll-free telephone hotline to respond to requests for assistance to consumers in their state
• SBE-FPs will be required to operate an informational internet web site that would direct consumers to Healthcare.gov to apply for, and enroll in, coverage through the Exchange

Standards Applicable to Navigators (§§155.210 and 155.215)
• Starting with grants awarded in 2018 within the FFE, Navigators must provide targeted assistance to serve underserved and/or vulnerable populations within the Exchange service area in an effort to enroll those hard to reach and reduce the number of remaining uninsureds
  – Assistance would still need to be provided to any consumer seeking help
  – Navigators in the FFE must provide other assistance, including post-enrollment assistance, such as understanding the Exchange eligibility appeals, applying for individual shared responsibility payment exemptions, etc.; SBEs will have the option of requiring or authorizing these activities
• Navigators are required to help consumers with:
  – Understanding basic concepts of health coverage and basic insurance terms, as well as their rights related to health coverage
    – Navigators must also complete training on consumers’ rights related to health coverage
  – Exchange-related components of the premium tax credit reconciliation process, such as ensuring access to their Form 1095-A, and helping them find Silver plan premiums using the Exchange tool
• Navigators are required to refer consumers to tax advisors or tax preparers for tax advice related to exemptions and payment of the individual shared responsibility and premium tax credit reconciliation, and Navigators must complete training on this topic
  – Navigators, as well as non-Navigator assistance personnel subject to §155.215 and certified application counselors, must provide consumers with a disclaimer that they are not acting as tax advisors or attorneys and therefore cannot provide tax or legal advice
• All exchanges will be required to set up Navigator training programs with minimum standards that must be met by all Navigators, to ensure expertise in specified areas, and that the training would need to be completed prior to performing any assister duties
  – For exchanges that require Navigators to perform any of the assistance topics outlined in §155.210 (e) (9), Navigators would be required to complete the corresponding training topic
• All Navigators, non-Navigator assistance personnel, application counselors, and other entities and individuals providing consumer assistance must complete training prior to participating in any outreach and education activities
• Gifts and promotional items of any value, including those from third parties, may not be provided by Navigators as inducement for enrollment
  – Gifts not provided as an inducement for enrollment may be provided as long as the cumulative value of all gifts provided in one encounter is nominal
  – Gifts are defined as gift cards, cash or promotional items that promote the products of a third party
  – Reimbursement of travel or postage expenses incurred in an effort to receive exchange application assistance is not considered a gift

Standards Applicable to Agents and Brokers (§155.220)
• HHS intends to have in place a process starting with the 2018 open enrollment period that would allow web-brokers to assist consumers in completing applications and enrolling in coverage through the Exchange
by remaining on the web-broker’s website and allowing their website to obtain eligibility information for the Exchange

- Web-brokers would be required to use the FFE application without deviation in language or order of steps for enrollment, however minor deviations that do not change the intent or meaning of a question, impact the probability of accurate answers, or affect the dependencies and structure of the application may be allowed with prior HHS approval
- The process of completing an application on a non-Exchange website would need to comply with all applicable Exchange standards, including notice requirements and privacy and security standards related to personally identifiable information
- The non-Exchange website must pass an HHS approval process before the non-Exchange website is used to complete Exchange eligibility applications

• Agents and brokers will be considered noncompliant if they violate the terms of the agreement with the FFE, and will be suspended or terminated in cases of fraud or abusive conduct
  - A 90-day suspension will be enforced in cases of suspected fraud or abuse regardless of whether the activity/conduct was committed directly by the agent or broker or through a third party
  - Suspension or termination is effective the day of notice in cases of suspected fraud or abusive conduct that may cause consumer harm, and with 30-day notice in all other cases to allow agents and brokers an opportunity to respond prior to termination
  - HHS must review and make a determination whether to lift the suspension within 30 days of receipt of evidence to rebut the allegation of fraud or abusive conduct
  - Failure to submit evidence to rebut the allegation of fraud or abuse within the 90-day suspension period may result in termination of the agreement

• HHS codified that agents and brokers must meet the following requirements:
  - Have a fully executed agreement with the Exchange
  - Be registered with the FFEs prior to assisting with or enrolling qualified individuals in the Exchange
  - Comply with the standards of conduct, which includes:
    - Providing consumers with correct information that is not misleading
    - Providing the FFEs with correct information
    - Obtaining consent of the individual or employer they are assisting with enrollment
    - Protecting consumer personally identifiable information
    - Complying with applicable Federal and State laws and regulations

• Failure to comply with the outlined agent and broker requirements may result in denial of the right to enter into agreements with the FFE in future years, and potentially a CMP
  - Denial of the right to enter into an agreement with the FFE in future years would be subject to 30 calendar days’ advance notice and a reconsideration process

• Agents and brokers enrolling individuals in SBE-FPs must comply will all of the requirements outlined for agents and brokers enrolling individuals in FFEs

Standards Applicable to HHS-Approved Vendors for FFE Training for Agents and Brokers (§155.222)

• Vendors responsible for training will no longer be required to:
  - Perform identification verification of agents and brokers as this function should be already performed by QHP issuers
  - Collect, store and share with HHS all data from agent and broker training
    - They will continue to be required to collect, store and share with HHS information on training completion

• Training vendors will be required to provide technical support to assist agents and brokers accessing the vendor's training platform
Standards Applicable to Certified Application Counselors (§155.225)

- In states using the FFE, starting in the third quarter of calendar year 2017, certified application counselor designated organizations will be required to provide quarterly information to the Exchange on:
  - The number and performance of the organization’s counselors
  - The type of consumer assistance being provided

4. Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

Eligibility Process (§155.310(h))

- The Exchange is no longer required to notify an employer that an employee is eligible for financial assistance through the Exchange, unless the employee actually enrolls in a QHP through the Exchange
  - Notification may be provided on an employee-by-employee basis or for groups of employees
  - Notification needs to be provided within a reasonable time frame

Verification Process Related to Eligibility for Insurance Affordability Programs (§155.320)

- Exchanges will be allowed to set up a reasonable threshold at which the Exchange must follow alternate income verification processes
  - The current threshold is when attested annual income is more than 10% below income data received from a trusted source
  - The threshold set by the Exchange must be at least 10%, can include a threshold dollar amount, and must be approved by HHS
  - HHS will provide additional guidance on what constitutes a reasonable threshold
- The Exchange is no longer required to select a statistically significant sample of applicants for whom the Exchange does not have data and take steps to contact the employer for employee verification, known as “sampling,” and can replace the process with a survey of verification procedures approved by HHS for 2016 and 2017

5. Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

Annual Eligibility Redetermination (§155.335(j))

- A new default re-enrollment hierarchy will be implemented for enrollees in Silver level QHPs where the product is no longer available for re-enrollment
  - The enrollee would be automatically enrolled in a Silver level QHP in the product offered by the same issuer that is most similar to the current product
  - In the unique circumstance in which an issuer is not returning to the Exchange, the FFE will attempt to re-enroll individuals currently enrolled in a Silver metal-level QHP that is no longer available through the Exchange into the Silver metal-level QHP of another issuer through the Exchange of the same product network type with the lowest premium
- Issuers that leave the Exchange may not automatically re-enroll members currently enrolled in their QHP plans into a non-Exchange plan

Enrollment of Qualified Individuals into QHPs (§155.400)

- HHS is implementing new requirements around payment of binder premium:
  - For prospective coverage, payment must consist of the first month’s premium and the deadline for payment can be no earlier than the coverage effective date and no later than 30 days after the effective date or the date the issuer receives the enrollment transaction, whichever is later
  - For retroactive coverage under a special enrollment, the binder premium must consist of all premium due and the deadline may be no earlier than 30 days from the date the issuer received notification of enrollment

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• Issuers would be allowed to set a threshold of less than 100% of the full premium as satisfying the obligation to pay premium and not place an enrollee into a grace period, for enrollees who receive advance premium tax credits (APTCs)

Annual Open Enrollment Period (§155.410)
• The open enrollment period for coverage year 2017 will run from November 1, 2016 through January 31, 2017
• The open enrollment period for coverage year 2018 will run from November 1, 2017 through January 31, 2018
• For coverage year 2019 and later, the open enrollment period will run from November 1 through December 15 of the year prior to the coverage year, with coverage effective the first day of the coverage year

Special Enrollment Periods (§155.420)
• The FFE will conduct an assessment under which it will review documents from consumers to confirm their eligibility for special enrollment periods and retroactively or prospectively end coverage if it is determined that the special enrollment period was improperly granted

Termination of Coverage (§155.430)
• The Exchange is allowed to cancel an enrollee’s coverage under certain circumstances, such as fraudulent enrollment that the Exchange discovers, even if the enrollee is never aware of the enrollment
• The Exchange may set a date after which retroactive terminations and cancellations for the preceding coverage year will no longer be granted
• Enrollees would be allowed to terminate coverage retroactively in certain circumstances:
  − If an enrollee experienced a technical error while attempting to terminate coverage and notifies the Exchange within 60 days
  − If an enrollee demonstrates to the Exchange within 60 days of discovering enrollment that was unintentional, inadvertent, or erroneous and was the result of error or misconduct of the Exchange, HHS or another entity providing enrollment assistance
  − If an enrollee demonstrates to the Exchange that the enrollment was without the enrollee’s knowledge or consent by any third party, and the enrollee requests cancellation within 60 days of discovering the enrollment
• The cancellation date of coverage in these circumstances would be the original coverage effective date or a later date, as determined appropriate by the Exchange based on the circumstances of the cancellation or termination

6. Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

Affordability Programs (§155.505)
• HHS clarified that an applicant or enrollee has the right to appeal a decision related to eligibility, and that an applicant or enrollee who disagrees with a decision made by a State Exchange appeals entity may appeal that decision to an HHS appeals entity within 30 days

Appeals Coordination and Requests (§155.510 – 155.530)
• An appeals entity or agency administering insurance affordability programs is allowed to request information or documentation from an appellant that has already been provided if the appeals entity or agency does not have access to the information, if that information is necessary to properly adjudicate the appellant’s appeal
• Prior to dismissing an untimely appeal, the appeals entity is required to notify an appellant that the request may be considered valid if the appellant can demonstrate within a reasonable timeframe that failure to submit information timely was due to exceptional circumstances
  − The appeals entity may define what constitutes an exceptional circumstance and may determine what is considered a reasonable timeframe for demonstrating an exceptional circumstance
• HHS will allow an appeal to continue after an appellant’s death
Informal Resolution and Hearing Requirements (§155.535)

- Exceptions to the requirement to provide 15 days written notice of an appeals hearing are allowed in the following circumstances:
  - The appellant requests an earlier hearing date
  - A hearing date sooner than 15 days is required in order to process an expedited request, and the appeals entity has contacted the appellant and the appellant’s authorized representative, if any, to schedule a hearing on a mutually agreed to date, time and location or format

Appeal Decisions (§155.545)

- The effective date of retroactive appeals decisions is the effective date the appellant did receive or would have received coverage if the appellant had enrolled in coverage under the incorrect eligibility determination that is the subject of the appeal

Employer Appeals (§155.555)

- If an employer submits an appeal and the decision impacts an employee’s eligibility for APTCs, the Exchange would be required to promptly re-determine the eligibility of the employee and the employee’s household members, and notify the employee of the requirement to report changes in eligibility to the Exchange

7. Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions

Eligibility Standards for Exemptions (§155.605)

- The Exchange will longer no make eligibility determinations for exemptions for membership in a health care sharing ministry, membership in an Indian tribe, or incarceration status
  - These individuals would simply file IRS Form 8965
- Hardship exemptions may be claimed on a Federal income tax return without a required Exemption Certificate Number (ECN) from the Exchange
  - Hardship exemptions must cover at least the period that starts one month before the hardship began and runs through the end of the coverage year in which the hardship began
  - Additional proof of a hardship is not required within three years of the initial application
- The requirement that individuals eligible for an exemption as a result of a State not expanding Medicaid eligibility under Section 2001(a) of the ACA obtain an eligibility determination from the State Medicaid office has been removed
  - An individual may claim an exemption on their Federal income tax return without obtaining an ECN from the Exchange

Required Contribution Percentage (§155.605(e)(3))

- HHS is replacing projections of per capita Gross Domestic Product from the National Health Expenditures Accounts with projections of Personal Income as published by the Office of the Actuary, when calculating the percentage of household income threshold used for determining whether an individual shared responsibility payment is due
  - The 2017 required contribution percentage under the proposed methodology would be 8.16% of household income
  - The required contribution percentage was 8.0% for 2014, 8.05% for 2015 and 8.13% for 2016

Eligibility Process for Exemptions (§155.610 – 155.625)

- When incomplete exemption applications are received, the Exchange must notify the applicant and provide them a period of between 30 and 90 days to provide the missing information
  - If the requested information is not received the Exchange must provide notification that the application will not be processed, and provide the applicant with their appeal rights
- State Exchanges will no longer be required to process exemption applications starting in 2016, and will be allowed to adopt exemption eligibility determinations made by HHS indefinitely
8. Exchange Functions: Small Business Health Options Program

Functions of a SHOP (§155.705)

- In addition to current options of offering a single plan or all plans at a given metal level, starting in 2017 employers will be able to select from a new choice option in the FF-SHOP which will allow them to offer their employees the choice of all plans across all metal levels from a single issuer
  - States with FF-SHOPs may recommend this vertical choice option not be offered in their State by issuing a letter to HHS justifying their recommendation
  - HHS recommends States submit these letters by March 25, 2016
  - SBE-FPs will have the authority to opt out of making this vertical choice available in their State and should notify HHS by March 25, 2016
  - State based SHOPs that already have this option will continue to be able to offer this option
- Payment of premium for a group's first month of coverage will need to be received by the premium aggregation services vendor by the 20th day of the month prior to the month that coverage begins
- In cases where a SHOP would retroactively effectuate coverage, HHS will require payment for the first month's coverage and all months of retroactive coverage no later than 30 days after the triggering event and by the 20th day of the month prior to the month that coverage begins
- A new employer contribution option will be added that will allow an employer to select a fixed contribution percentage that will be applied across all plans in which a qualified employee may enroll; this option will be in addition to the reference plan option in place today
  - Under both employer contribution options the employer’s contribution will be calculated based on the non-tobacco user premium rate with the tobacco surcharge borne entirely by the tobacco user
  - If the employer offers only a single plan, they will be required to use the newly proposed fixed contribution methodology
- Language related to composite premiums will be modified to indicate that FF-SHOPs may permit employers to base employer contributions on composite premiums, however FF-SHOPS are not currently able to support this option

Enrollment Periods Under SHOP (§155.725)

- Employers offering coverage through the FF-SHOP will be required to provide qualified employees an annual open enrollment period of at least one week for renewals
- Employers enrolling in the FF-SHOP will be allowed to select a coverage effective date up to two months in advance
  - If an employer submits group enrollment information by the 15th of the month, coverage could begin as early as the first day of the following month
- The SHOP will be allowed, but will not be required, to provide auto-renewal of employees into the QHP in which they are currently enrolled

Termination of SHOP Enrollment or Coverage (§155.735)

- Issuers offering coverage in the FF-SHOP will be required to send a notice to qualified employees 90 days prior to one of their children no longer being eligible for coverage due to reaching the maximum child dependent age for the plan

SHOP Employer and Employee Eligibility Appeals Requirements (§155.735)

- Employers and employees will be able to file an appeal if either the SHOP fails to provide an eligibility determination in a timely manner or if the SHOP fails to provide timely notice of an eligibility determination
- Employers and employees who successfully appeal a denial may receive coverage retroactive to the date coverage would have been effective if they had correctly been determined eligible, but will also be able to select from a new option of having an effective date equal to the first of the month following the date of the appeal decision notice
9. Exchange Functions: Certification of Qualified Health Plans (§155.1000)

• HHS will continue to base denials of certification in the FFES for health plans that would otherwise meet QHP certification standards on the “interest of qualified individuals and qualified employers,” and may deny certification for:
  − Concerns related to an issuer’s material noncompliance
  − An issuer’s financial insolvency
  − Data errors related to QHP applications and data submissions

G. HEALTH INSURANCE ISSUER STANDARDS UNDER THE ACA, INCLUDING STANDARDS RELATED TO EXCHANGES

1. Standardized Options

• HHS has established standardized benefit options to be offered in the individual market to simplify the consumer plan selection process
  − One standard plan was designed at each of the Bronze, Silver (and corresponding CSR plan variations) and Gold levels
  − The plans have standardized cost sharing for a key set of EHBs that comprise a large percentage of the total allowed cost
  − Issuers are not required to offer the standardized plan options in 2017

• Standardized options utilize four drug tiers: generic, preferred brand, non-preferred brand and specialty drug tiers, with the option for issuers to offer an additional lower cost generic tier, if desired

• Standardized options only have one in-network provider tier

• Certain services such as primary care, specialist visits, and generic drugs are covered prior to meeting the deductible

• Key features of the 2017 standard plans are as follows:

<table>
<thead>
<tr>
<th>BENEFIT PROVISION</th>
<th>BRONZE</th>
<th>SILVER</th>
<th>SILVER (73% AV)</th>
<th>SILVER (87% AV)</th>
<th>SILVER (94% AV)</th>
<th>GOLD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial Value</td>
<td>61.88</td>
<td>70.63</td>
<td>73.55</td>
<td>87.47</td>
<td>94.30</td>
<td>79.98</td>
</tr>
<tr>
<td>Deductible</td>
<td>$6,650</td>
<td>$3,500</td>
<td>$3,000</td>
<td>$700</td>
<td>$250</td>
<td>$1,250</td>
</tr>
<tr>
<td>Annual OOP</td>
<td>$7,150</td>
<td>$7,150</td>
<td>$5,700</td>
<td>$2,000</td>
<td>$1,250</td>
<td>$4,750</td>
</tr>
<tr>
<td>PCP Office Visits</td>
<td>First 3 $45*; fourth+ ded &amp; coins.</td>
<td>$30*</td>
<td>$10*</td>
<td>$5*</td>
<td>$20*</td>
<td></td>
</tr>
<tr>
<td>Specialist Visit</td>
<td>50%</td>
<td>$65*</td>
<td>$65*</td>
<td>$25*</td>
<td>$15*</td>
<td>$50*</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>50%</td>
<td>$400 after deductible</td>
<td>$300 after deductible</td>
<td>$150 after deductible</td>
<td>$100 after deductible</td>
<td>$250 after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>50%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>5%</td>
<td>20%</td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>$35*</td>
<td>$10*</td>
<td>$10*</td>
<td>$5*</td>
<td>$3*</td>
<td>$10*</td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>35%</td>
<td>$50*</td>
<td>$50*</td>
<td>$25*</td>
<td>$5*</td>
<td>$30*</td>
</tr>
</tbody>
</table>

* Not subject to deductible

• An issuer may offer multiple standard plans at a given metal level, as long as they are meaningfully different (e.g., an HMO and a PPO option)

• HHS is not limiting the total number of plans an issuer may offer at a given metal level in 2017, but may in the future in order to simplify the consumer shopping experience

• HHS will modify the consumer comparison tool based on feedback currently being obtained from consumers
2. **FFE User Fee for the 2017 Benefit Year (§156.50)**
   - The user fee rate for issuers offering coverage through the FFE in 2017 will be 3.5% of premium, unchanged from the 2014-2016 fee
     - HHS notes that this fee is not expected to fully cover the cost of operating the FFE, and that they have sought an exception from the requirement that the user fee be sufficient to recover the full cost to the Federal government
   - The user fee rate for issuers offering coverage through the SBE-FP in 2017 will be 1.5% of premium
     - While HHS’s actual cost are anticipated to be 3.0% of premium, given the abrupt shift to charging a user fee in states that have been using the Federal portal, HHS has sought a waiver and will charge 1.5% of premium in 2017
     - SBE-FPs wishing to assess the fee in a different manner (e.g., across all policies sold both on and off the Exchange) may do so in which case HHS will collect from the SBE-FP the total amount that would have resulted from the 1.5% user fee

3. **Single Risk Pool (§156.80)**
   - HHS is codifying prior guidance that when rates in the small group market are changed on a quarterly basis the new rates must apply for the entire plan year

4. **Essential Health Benefits Package**
   **Prescription Drug Benefits (§156.122)**
   - When an enrollee files an appeal to gain access to a clinically appropriate non-formulary drug, the cost of the non-formulary drug provided through the exceptions process must count toward the annual limit on cost sharing
     - HHS amended the requirement so that in states that have coverage appeals laws that are more stringent that the Federal requirements, and that include internal and external reviews for non-formulary drugs including the ability to expedite reviews under time frames that are the same or shorter than the Federal requirement, the State requirements satisfy the Federal requirement
     - Issuers are not required to include a second level of internal review, using the same timelines as the first level of internal review (72 hours for standard review; 24 hours for expedited review), but may elect to do so

   **Premium Adjustment Percentages (§156.130)**
   - The maximum annual limitation for cost sharing, the required contribution percentage for minimum essential coverage (MEC), and the large employer penalty are adjusted annually by the percentage by which average per capita premium for health insurance for the prior year exceeds the average per capita premium for health insurance for 2013
     - The 2017 adjustment percentage was calculated to be 13.3%, based on the projected increase of 2016 premium over 2013 premium by the National Health Expenditure Accounts (NHEA) for employer-sponsored coverage
     - Results are rounded to the next lowest multiple of $50; family provisions are twice the single levels
   - Maximum out-of-pocket (MOOP) limits for 2017 are $7,150 for self-only and $14,300 for other than self-only coverage

   **Reduced Maximum Annual Limitation on Cost Sharing (§156.130)**
   - MOOP limits for CSR plans for self-only coverage are as follows:

<table>
<thead>
<tr>
<th>FPL</th>
<th>AV</th>
<th>REDUCTION IN MOOP</th>
<th>2016 MOOP SELF-ONLY</th>
<th>2016 MOOP OTHER THAN SELF-ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-150%</td>
<td>0.94</td>
<td>2/3</td>
<td>$2,350</td>
<td>$4,700</td>
</tr>
<tr>
<td>150-200%</td>
<td>0.87</td>
<td>2/3</td>
<td>$2,350</td>
<td>$4,700</td>
</tr>
<tr>
<td>200-250%</td>
<td>0.73</td>
<td>1/5</td>
<td>$5,700</td>
<td>$11,400</td>
</tr>
</tbody>
</table>
AV Calculation for Determining Level of Coverage (§156.135)

- HHS intends to revise the requirements for updating the AV Calculator in the future to allow for additional flexibility
  - The AV Calculator could be updated for material changes in cost, plan design the standard population, the functional operation of the AV Calculator, and other actuarially relevant factors
  - Timelines and materiality thresholds for updating continuance tables to reflect more current enrollment and claims data would no longer be specified by regulation

Application to Standalone Dental Plans inside the Exchange (§156.150)

- HHS will update the annual limitation on cost sharing for standalone dental plans (SADPs) for plan years beginning after 2017
  - The new limitation for one covered child will be calculated as the 2017 limitation, times the ratio of the consumer price index for dental services (CPI-Dental) for the year that is two years prior to the benefit year, divided by the CPI-Dental for 2016
    - The result would be rounded down to the next lowest multiple of $25
  - The new limitation for two or more covered children will be twice the new limitation for one covered child

5. Qualified Health Plan Minimum Certification Standards

Network Adequacy Standards (§156.230)

- HHS will not make revisions to network adequacy standards, but instead intends to give states time to adopt the NAIC’s Network Adequacy Model Act
- HHS will continue the process used in previous years to review network adequacy as part of the annual certification process and will publish details of that process, including the metric used, for transparency purposes
- QHP issuers in FFEs will be required to notify enrollees when there is a discontinuance in the network coverage of a contracted provider 30 days prior to the effective date of the change
  - Notification must be made to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider
  - In cases where a provider is terminated without cause, enrollees who are receiving active treatment will continue to be able to receive care at the in-network cost share rate for the shorter of (a) the remainder of the treatment or (b) 90 days if they are receiving active treatment, where active treatment is defined as:
    - An ongoing treatment for a life-threatening condition (one in which death is probable unless the course of treatment is uninterrupted)
    - An ongoing course of treatment for a serious acute condition (a condition requiring complex ongoing care)
    - The second or third trimester of pregnancy and corresponding postpartum period
    - An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that provider would interfere with anticipated outcomes
- Requests for continuity of care will be subject to the health benefit plan’s internal and external grievance and appeal processes
- These Federal requirements would not preempt State laws that are substantially similar or more stringent if the State adopts these parts of the NAIC Network Adequacy Model Act
- When a provider leaves the network but the provider practice remains in the network, the provider practice rather than the issuer must provide the notification to the enrollee
- Starting with the 2018 benefit year, in order to meet network adequacy standards, QHPs both on and off exchanges must count all cost sharing paid toward an EHB provided by an out-of-network ancillary provider in an in-network setting toward the enrollee’s in-network annual limitation on cost sharing
This provision will not apply if the plan provides a written notice to the enrollee by the shorter of the issuers prior authorization period or 48 hours prior to the scheduled service that additional costs may be incurred for an EHB provided by an out-of-network provider in an in-network setting, including balance billing:

- The issuer will not be able to rely on a blanket notification such as on its website or at the time of enrolment.
- The provision will not apply to QHPs that do not cover out-of-network services.

HHS intends to implement a QHP network breadth rating:

- The rating will be based on the number of specific providers within the county that are accessible within specified time and distance standards within a plan's network, divided by the total number of QHP providers in the county.
- QHP networks will be placed into one of three categories.
- Additional details on the classification of networks are provided in the Letter to Issuers and in the QHP Certification instructions.
- The rating will be posted on HealthCare.gov to help an enrollee select the plan that best meets his or her needs.

**Essential Community Provider Standards (§156.235)**

- In December 2015 HHS launched an ECP petition initiative allowing providers the opportunity to be added to an essential community providers (ECPs) list.
  - The ECP petition submission window will remain open throughout the year to allow providers to report fluctuations.
  - ECPs with practitioners who divide their time among several facilities should divide their FTE counts among the facilities when completing the petition.

For 2017, multiple providers at a single location will continue to be counted as a single ECP toward both the available ECPs in the plan's service area and the issuer satisfaction of the ECP participation standard:

- Starting in 2018, issuers will be credited for multiple contracted FTE practitioners at a single location, up to the number of available FTE practitioners reported to HHS by the ECP facility.
- Each FTE practitioner included in the network will be counted in the numerator of issuer's percentage satisfaction of the ECP standard, and the denominator will include the number of available FTE practitioners reported to HHS by each ECP facility on the HHS ECP list for the issuer's service area.

**Enrollment Process for Qualified Individuals (§156.265)**

- In time for the open enrollment period for coverage in 2018, HHS intends to implement an option under which an applicant could remain on a QHP issuer's website to complete the application process for coverage through the Exchange, rather than being redirected to the Exchange.
  - The issuer's website must use the exact same eligibility application language as in the FFE Single Streamlined Application and submit information through an Exchange-approved web service, unless modifications which are expected to be minor are approved by HHS.

**Termination of Coverage or Enrollment for Qualified Individuals (§156.270)**

- The requirement that QHP issuers provide a three-month grace period to an enrollee eligible for APTCs and does not pay premiums on time has been amended to apply even if the enrollee loses eligibility for APTCs during the grace period.
- Language limiting the three-month grace period for enrollees who are receiving APTC to only those enrollees who made a payment during the benefit year has been eliminated.
- An issuer’s premium payment threshold under which an enrollee is considered to have paid their premium in full will be extended to enrollees who are in the grace period for non-payment of premium.
Additional Standards Specific to SHOP (§156.285)

- QHP Issuers will be required to send monthly enrollment reconciliation files to the FF-SHOP.
- If a qualified employer withdraws from the SHOP, the SHOP and not the issuer is responsible for terminating the employer’s enrollment through the SHOP.

Meaningful Difference Standard for Qualified Health Plans in the Federally-Facilitated Exchanges (§156.298)

- Health savings account eligibility has been removed as a criterion.
- Self-only vs. non-self-only has been removed as a criterion that would differentiate a plan from an otherwise identical plan; child-only plans remains meaningfully different from non-child-only plans.


- QHP issuers offering coverage through SBE-FPs will be required to follow the same requirements related to eligibility and enrollment that are applicable to QHP issuers offering coverage through the FFE.
- SBE-FPs will need to provide plan data to HHS by dates specified in the annual Letter to Issuers.
- In cases where the SBE-FP does not enforce the eligibility and enrollment standards, HHS will be able to take enforcement action against the QHP issuers or plans.

7. Enforcement Remedies in Federally-Facilitated Exchanges (§156.800, §156.805, §156.810)

- In cases where an issuer is assessed a CMP and the issuer files a request for a hearing, the CMP assessment will be suspended until a final administrative decision on the appeal has been made.
- Starting in 2016, sanctions could be imposed if a QHP issuer fails to comply with applicable standards of the FFE, even if the issuer made a good faith effort to comply.
- HHS will take all necessary steps to suppress and/or decertify a QHP in cases where the QHP issuer has notified HHS that it cannot continue to provide coverage under a QHP.
- Additional bases for decertification will be added which include scenarios where the QHP issuer is the subject of a pending or existing State enforcement action related to offering coverage in the FFE or where HHS believes the QHP issuer lacks financial viability to continue providing QHP coverage until the end of the year.

8. Quality Standards (§156.1110)

- Beginning January 1, 2017, a QHP issuer that contracts with a hospital with more than 50 beds will be required to:
  - Verify that the hospital uses a patient safety evaluation system as defined in 42 CFR 3.20.
  - Ensure that the hospital implemented a comprehensive person-centered discharge program to improve care coordination and health care quality.
- If not working with a patient safety organization (PSO), QHP issuers must use some other means to verify that hospitals with more than 50 beds implement evidence based initiatives to reduce all causes of preventable harm, prevent hospital readmissions, improve care coordination, and improve health care quality by collecting, managing and analyzing patient safety events.
- For plan years beginning on or after January 1, 2017, QHP issuers will be required to document that each contracted hospital with more than 50 beds meets required patient safety standards:
  - Collection of CMS certification numbers (CCNs) could be used to demonstrate that the hospitals implement mechanisms for comprehensive person-centered hospital discharge.

9. Qualified Health Plan Issuer Responsibilities

Payment and Collection Processes (§156.1215)

- APTCs, CSR payments, fees and assessments for premium stabilization programs will be netted against each other for QHP issuers in SBE-FPs, similar to the process currently used for QHP issuers in the FFE.
Administrative Appeals (§156.1220)

- The current administrative appeals process for QHP issuers in the FFE will be extended to SBE-FPs.
- A reconsideration related to risk adjustment or reinsurance will only be able to be requested if an issue that could have been identified by the issuer to HHS under the discrepancy reporting process was identified and remains unresolved.
  - Only processing errors by HHS, HHS’s incorrect application of the relevant methodology, or mathematical errors by HHS will continue to be considered.
- QHP issuers may not file a request for reconsideration related to the risk corridor program that challenges the standards of the program or is related to data for programs other than risk corridors.
- The deadline for filing a reconsideration related to a processing error by HHS, HHS’s incorrect application of the relevant methodology, or mathematical errors by HHS will be reduced from 60 days to 30 days for risk adjustment, transitional reinsurance, and risk corridors.
  - Reconsiderations related to the APTCs, CSRs, and FFE user fee programs will continue to have a 60-day deadline.
  - The full amount owed as set forth in the applicable notification must be paid while a reconsideration request is being evaluated, with any applicable refund paid upon a successful appeal.

Third Party Payment of Qualified Health Plan Premiums (§156.1250)

- HHS clarified that QHP issuers must accept premium and cost sharing payments made on behalf of enrollees in the following circumstances:
  - When premiums are paid by the Ryan White program.
  - When premiums are paid by other Federal and State government programs that provide premium and cost sharing support for specific individuals. This includes:
    - Programs of political subdivisions of the State (e.g., counties and municipalities) which are authorized to distribute care and exchange financial assistance to the State’s vulnerable populations.
    - Government grantees authorized and funded by Federal, State or local government programs to make the payments on behalf of the State or Federal program.
  - When premiums are paid by Indian tribes, tribal organizations, or urban Indian organizations.

Other Notices (§156.1256)

- Issuers will be required to notify enrollees within 30 calendar days after the issuer is notified by the FFE or SBE-FP that an error in the display of plan or benefit information on the FFE has been fixed, if directed by the FFE or SBE-FP.
  - Notification of these errors will trigger a special enrollment period during which an insured can change plans.
  - Errors that require notifying enrollees and trigger a special enrollment period include the incorrect display of service areas, covered benefits and premiums; errors in the display of networks or pharmacy formularies generally would not trigger a special enrollment period.

H. ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

1. Reporting of Incurred Claims (§§158.103 and 158.140(a))
   - HHS confirmed that the number of months of claims runout required to be used when estimating incurred claims for MLR reporting will remain three months.

2. Reporting of Fraud Prevention Expenditures
   - HHS considered amending the MLR regulations to permit the counting of investment in fraud prevention activities as an expense attributable to incurred claims, however no changes are being made at this time.
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