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Health Care Reform Alert

November 23, 2015

Proposed Regulations on 2017 Benefit and Payment Parameters

On November 20, the Department of Health and Human Services (HHS) issued proposed regulations that address a wide range of Affordable Care Act (ACA) benefit provisions that will be effective for 2017 plan years. These rules are published each fall and finalized the next spring for the following plan year.

On the same day, the Centers for Medicare & Medicaid Services (CMS) posted the draft 2017 Actuarial Value Calculator, along with the 2017 Methodology and User Guide. Links to the calculator and related documents can be found at the end of this alert.

Here is an overview of some of the key provisions in the proposed regulations.

2017 Out-of-Pocket Maximums

The proposed 2017 annual out-of-pocket maximums are $7,150 for individual coverage and $14,300 for family coverage.

2017 Marketplace Enrollment Period

The 2017 enrollment period will follow the same timing as 2016 enrollment: November 1, 2016 through January 31, 2017.

The proposed rules suggest changes to the automatic re-enrollment process when the plan in which an individual is currently enrolled is no longer available. Individuals who had been enrolled in a silver plan that is no longer available would be auto re-enrolled in the most similar silver plan product offered by the same insurer, rather than in a different metal level in the same product.

2017 User Fee

The fee insurers pay to sell individual policies through the Marketplace will remain at 3.5% of the monthly premium.

Network Adequacy Standards

The rules propose several changes related to network adequacy requirements for plans

sold on the Marketplace.

- **Treating certain out-of-network expenses as in-network** – Insurers offering plans in any Marketplace would have to provide individuals at least 10 days' notice prior to a procedure at an in-network facility if the individual might receive out-of-network services, for example from an out-of-network anesthesiologist. If the notice is not provided, the individual would be allowed to count the out-of-network cost sharing against his or her in-network out-of-pocket maximum.
- **Standards for network coverage** – The rules would establish provider network adequacy standards for health plans in the federal Marketplace. These standards would cover factors such as consumer travel time and distance to providers. HHS is also considering creating standards for identifying network strength to improve transparency for consumers.
- **Coverage when a provider leaves the network** – The rules would impose new continuity-of-care requirements in the federal Marketplace. Insurers would have to provide 30 days' notice before discontinuing a network provider. If an individual is receiving active treatment, the insurer would have to cover continuing care for up to 90 days or until treatment is completed.

Standardized Plan Options in the Individual Marketplace

To make it easier for consumers to compare costs for similar plans offered by different insurers in the federal Marketplace, certain plans will be designated as standardized plans. The current proposal includes four silver, one bronze and one gold plan. Insurers can choose to offer standardized plans, non-standardized plans or both. The standardized plans would have:

- Standard deductible amounts
- Four-tier drug formularies
- Only one in-network provider tier
- Some services, such as office visits, urgent care and generic drugs, not subject to the deductible
- A preference for copayments over coinsurance

New Model for State/Federal Partnerships

State Marketplaces that use HealthCare.gov's technology for eligibility and enrollment will be known as state-based exchanges on the federal platform (SBE-FPs). States will retain primary responsibility for plan management and consumer assistance while using the federal enrollment system, including certain call center services. This model is intended to make the transition easier should additional states decide to move to HealthCare.gov in the future.

Navigator Responsibilities

The proposed regulations modify the requirements that apply to navigators. Navigators would be required to provide post-enrollment assistance for functions such as Marketplace eligibility appeals, application for exemptions through the Marketplace, and transitioning from coverage to care.

Marketplace Enrollment Directly on Insurer's Websites

The proposed rules request comments on standards that would allow insurers and web-brokers to directly enroll individuals in the Marketplace while remaining on their own website.

Changes to Federally-Facilitated SHOP Plans

HHS proposes a new employee choice option on the SHOP Marketplace for small employers. Employers can currently offer their employees a single plan or the choice of plans within a metal level. Under the new “vertical choice” model, employers would be able to offer employees a choice of all plans across all available levels of coverage from a single insurer.

Read the Fact Sheet
Read the Proposed Regulations
View the 2017 Draft Actuarial Value Calculator and User Guide
Review the Calculator Methodology

We encourage you to bookmark Cigna's health care reform website, http://www.informedonreform.com/, where we continuously update information as it becomes available.

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