Acadia
BENEFITS INC.

Benefit and Payment Parameters Rule and HIP FAQ

The 2017 Benefit and Payment Parameters (BPP) rule, an annual rule that sets policies relating to the Patient Protection and Affordable Care Act (ACA), has been released by the Centers for Medicare and Medicaid Services (CMS). The 2017 rule contains numerous updates, including the annual open enrollment periods for the individual market, rating areas for small group health plans, guaranteed availability and renewability, broker and agent registration to assist consumers with applying for Exchange coverage, the employer notice system when its employees are determined to be eligible for a tax credit, and exemptions to the individual mandate. The rule also set cost sharing limits for 2017.

In conjunction with the rule, the Department of Health and Human Services (HHS) released an FAQ on the implementation of the 2017 moratorium on the Health Insurance Provider (HIP) fee. The FAQ states that insurers will not be charged the HIP fee for the 2017 fee year, based on 2016 information. Insurers should adjust premiums downward as a result.

Finally, HHS also released a bulletin that extends transitional plans from expiring on October 1, 2017, to the end of 2017 to allow individuals to enroll in an ACA-compliant plan beginning in calendar year 2018, rather than having to account for October through December 2017 prior to the new calendar year.

Cost Sharing Limits

The rule set the 2017 maximum annual limitation on cost sharing at $7,150 for self-only coverage and $14,300 for other than self-only coverage.

Open Enrollment – Exchange

Open enrollment for 2017 and 2018 will be from November 1 until January 31. No new special enrollment periods are being added, and no current special enrollment periods are being eliminated.

Employer Notice

Employers will be notified when an employee actually enrolls in a qualified health plan through the Exchange. Currently employers are notified when an employee is determined to be eligible for federal financial assistance. The Exchange can either notify employers on an employee-by-employee basis or for groups of employees who enroll with financial assistance. The notice employers receive will indicate that the law prohibits retaliation against employees who receive financial assistance on the Exchange.

Standardized Plans

The BPP rule also contains numerous policies and updates relating to qualified health plans (QHPs) or those that are sold on a federally-facilitated Exchange (FFE) or the Marketplace. The rule will allow for six standardized plans on the Marketplace: bronze, gold, silver, and three silver plans at actuarial values of 73 percent, 87 percent, and 94 percent.

Large and Small Employer Definition

The rule redefines large and small employer to conform with the PACE Act. A large employer is an employer with at least 51 employees during the plan year, and a small employer has at least one but no more than 50 employees during the plan year. States can choose to define large employers as those with more than 101 employees, and small employers as those with no more than 100 employees.

Reinsurance Fee

The reinsurance program ends after then 2016 benefit year. The fees associated with the program will be paid for the last time for the 2016 year.

Rating Area

The BPP rule defines the geographic rating area of a small business as the area of the principal business address. However, if the principal business address is not a substantial worksite, the geographic rating area is where the greatest number of employees of the policyholder works. If for a network plan the group policyholder's principal business address is not within the plan's service area, and employees live, work, or reside within the service area, the principal business address is the address within the plan's service area where the greatest number of employees work as of the beginning of the plan year. If there is no such address, the rating area for the network plan is the rating area that reflects where the greatest numbers of employees live or reside.

Guaranteed Availability and Renewability

The ACA requires insurers in all markets to guarantee availability of non-grandfathered products to all applicants (there are some exceptions). Insurers can refuse to cover small groups that do not meet minimum participation requirements or the employer doesn't make minimum premium contributions, except during an annual open enrollment period from November 15 to December 15. Practically speaking, small employers who struggle to meet participation requirements should coordinate their open enrollment period with the open enrollment period for guaranteed availability and renewability.

Brokers, Agents, and the Exchange

In 2018, web brokers or agents will be able to use an "enhanced direct enrollment process" in the FFE as well as state-based Exchanges. This will allow consumers to stay on the web broker or insurer's website to apply for and enroll in coverage. Brokers and agents must still receive training for and register with the Exchange in order to assist consumers with enrollment, as well as sign a privacy and security agreement.

Exemptions

The individual responsibility requirement requires most individuals to either have qualifying health coverage or pay a tax, unless they are exempt. Members of health care sharing ministries, Indian tribes, and incarcerated individuals remain exempt. Individuals who would have been eligible for Medicaid if their state had expanded Medicaid may qualify for an exemption without going through the process of applying for and being denied Medicaid.

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