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REFORM UPDATE

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UPDATES ON SUMMARY OF BENEFITS COVERAGE (SBCs) AND AFFORDABILITY CALCULATIONS 2017 BENEFIT AND PAYMENT PARAMETERS

This *Reform Update* will review:

- The new SBC template
- The updated affordability percentage
- The final regulations on the 2017 Benefit and Payment Parameters

Employers need to keep up-to-date on the changing requirements of the Affordable Care Act (ACA).

FINAL SBC TEMPLATE

A new, streamlined SBC template is being adopted. It will apply to plan years beginning on or after April 1, 2017, including the annual enrollment period associated with that plan year. To date, only a proposed template had been released by the Department of Labor. It was discussed in our *Reform Update* at http://mcgrawwentworth.com/wp-content/uploads/Reform-Update-119.pdf.

The final new SBC template was posted recently. In addition, all the materials needed to complete the SBC and the updated uniform glossary have been finalized. The materials can be found at http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html. These templates and materials are relatively unchanged from the previous version.

UPDATED AFFORDABILITY PERCENTAGE

The IRS recently released Revenue Procedure 2016-24. This procedure includes the indexed percentage for testing affordability under certain provisions of the ACA. For plan years beginning in 2017, that amount is 9.69 percent. The indexed percentage will apply to the Marketplaces when they try to determine if employer coverage is affordable based on household income, and whether an individual is eligible for premium subsidies. The increased percentage will also be used by employers when testing for affordability based on any of the following safe harbors:

- Box 1 of the W-2
- Rate of pay
- Federal Poverty Level (FPL)

Finally, the updated affordability percentage will apply to any aspect of the reporting requirements that refer to affordability. For example, for plan years beginning in 2017, a qualifying offer will be defined as:

> A Qualifying Offer is an offer of MEC providing minimum value to a full-time employee for all calendar months during the calendar year for which the employee was a full-time employee for whom a section 4980H assessable payment could apply, at an employee cost for employee-only coverage for each month not exceeding 9.69 percent of the mainland single federal poverty line divided by 12, provided that the offer includes an offer of MEC to the spouse and dependent children.

The 4980H assessable payment refers to potential penalties under the ACA “pay or play” requirements (officially known as the Shared Responsibility requirements).

2017 BENEFIT AND PAYMENT PARAMETERS

Every year, the Department of Health and Human Services (HHS) is required to issue the Benefit and Payment Parameters under the ACA. These parameters address various issues related to employer-sponsored health plans, premium stabilization programs and Marketplace operations and requirements. Any plan changes required in these regulations are effective for plan years beginning on or after January 1, 2017.

The following summarizes the key issues:

2017 Maximum Out-of-Pocket Maximums

The 2017 annual out-of-pocket maximums will be $7,150 for individual coverage and $14,300 for family coverage. In 2016, health plans were required to embed the single out-of-pocket maximum. This means one family member’s out-of-pocket cost for essential health benefits received in-network cannot exceed $7,150 in 2017.

Marketplace Enrollment Period

Each year the Marketplace has an open enrollment period. Initially, it was to be held from November 1 to December 15 each year. However, due to challenges with the Marketplace, the open enrollment period has not followed the statutorily set time period.

The open enrollment period for 2017 and 2018 will follow the same timing as in 2016. It will run from November 1 through January 31 of the following year. Individuals who want to secure coverage effective January 1 must make their plan elections by December 15.

For 2019 and future years, the annual enrollment period will be held from November 1 through December 15.

Individuals enrolled in a Marketplace plan can continue that coverage without a positive election each year. However, the Marketplaces may enroll consumers in a plan offered by another insurer if the current insurer does not have a plan available for re-enrollment through the Marketplace.

Marketplace Eligibility Notifications to Employers

Beginning in 2017, the Marketplace will be required to notify an employer as soon as possible when one of its employees first enrolls in subsidized Marketplace coverage. Some state Marketplaces are currently providing this notification, but it is not universal.

Notification at the point of enrollment will help both employers and the government. By receiving immediate notification, employers will have the opportunity to work with the government in cases where an improper subsidy has been provided to an employee. It will also help employers to avoid any potential penalties and penalty appeals.

The ACA limits how much an individual is required to repay the government when the tax credit received exceeds what is permitted under law. The immediate notice will allow the Marketplace to verify if the employer-sponsored health coverage available to an employee is affordable and offers minimum value.

Standardized Plan Options in the Individual Marketplace

The Marketplace offers four categories of plans – bronze, silver, gold and platinum. The type of plan is determined by the actuarial value. Bronze has a 60 percent value, silver a 70 percent value, gold an 80 percent value and platinum a 90 percent value.

These final regulations include standardized plan options in the bronze, silver, and gold actuarial tiers for 2017. Three options are available in the silver tier. The values were adjusted to provide reduced cost-sharing. Individuals with a household income of 250 percent or less of the Federal Poverty Limit (FPL) are eligible for less cost-sharing in the silver plan. This reduced cost-sharing is set at actuarial values that are higher than the 70 percent standard silver plan.

	Bronze	Silver	Gold	Silver Adjusted (73%)	Silver Adjusted (87%)	Silver Adjusted (94%)
Actuarial Value	61.88%	70.63%	79.98%	73.55%	87.47%	94.30%
Deductible	$6,650	$3,500	$1,250	$3,000	$700	$250
Annual Limitation on Cost-Sharing	$7,150	$7,150	$4,750	$5,700	$2,000	$1,250
Emergency Room Services	50%	$400 copay applies only after deductible met	$250 copay applies only after deductible met	$300 copay applies only after deductible met	$150 copay applies only after deductible met	$100 copay applies only after deductible met
Urgent Care	50%	$75*	$65*	$75*	$40*	$25*
Inpatient Hospital	50%	20%	20%	20%	20%	5%
Primary Care Visit	$45 for first 3 visits, then subject to deductible and 50% coinsurance	$30*	$20*	$30*	$10*	$5*
Specialist Visit	50%	$65*	$50*	$65*	$25*	$15*
Mental Health/ Substance Abuse Outpatient	$45*	$30*	$20*	$30*	$10*	$5*

	Bronze	Silver	Gold	Silver Adjusted (73%)	Silver Adjusted (87%)	Silver Adjusted (94%)
Imaging (CT/PET Scans/MRIs)	50%	20%	20%	20%	20%	5%
Lab Services	50%	20%	20%	20%	20%	5%
X-rays	50%	20%	20%	20%	20%	5%
Skilled Nursing Facility	50%	20%	20%	20%	20%	5%
Outpatient Facility Fee	50%	20%	20%	20%	20%	5%
Outpatient Surgery	50%	20%	20%	20%	20%	5%
Generic Drugs	$35*	$15*	$10*	$10*	$5*	$3*
Preferred Brand Drugs	35%	$50*	$30*	$50*	$25*	$5*
Non-Preferred Brand	40%	$100*	$75*	$100*	$50*	$10*
Specialty Rx	45%	40%*	30%*	40%*	30%*	25%*

*Not subject to deductible

Insurance carriers in the Marketplace will have the option of offering one or more of the standardized options. They are being offered to make it easier for consumers to compare cost differences among various carriers using a standardized benefit plan, rather than an actuarial value. These plans will be displayed differently from other plan options to make them easier for consumers to find.

It is interesting that none of the standardized plans meet the requirements for a qualifying high deductible health plan paired with a health savings account (HSA). The preamble to the final regulations provided some insight. In many cases, the sizable deductible negatively affects participant utilization. Many individuals choose not to buy an HSA-compatible plan because only preventive care services are covered prior to meeting the deductible.

Network Adequacy Standards

Network access was one of the issues members had with Marketplace plans. Many of the plans sold on the Marketplace had a more limited network than the products sold to employers. In addition, the directories associated with the individual plans were not always up-to-date. After enrolling in a plan, individuals often discovered that their physicians did not participate in the network.

Previous regulations required plans to have an updated provider directory available to applicants and members. The final rules have adopted several changes related to network adequacy requirements for Marketplace plans:

- **Transparency of network size** – Beginning in 2017, HealthCare.gov plans will include a rating of each plan's relative network size compared to other plans available in the same geographic area. This will help purchasers to evaluate different plans.
- **Coverage when a provider leaves the network** – New continuity-of-care requirements will apply to the Marketplace. Insurers must provide 30 days' advance notice to patients receiving treatment from a provider who is leaving the network. Insurers will have to continue in-network

coverage for individuals receiving active treatment, until the treatment is complete or for 90 days, whichever occurs first.

- **Treating certain out-of-network expenses as in-network** – Beginning in 2018, cost-sharing amounts for certain services performed by out-of-network ancillary providers (for example, anesthesiologists) at in-network facilities must be counted toward the in-network, annual out-of-pocket maximum. The only time these services can apply to the out-of-network maximum limit is if the insurance carrier provides advanced written notice to the patient. Notice must be provided at least 48 hours in advance. This is intended to help limit potentially large "surprise bills" for members.

The government will continue to monitor issues related to Marketplace plans and network standards.

Changes to Federally Facilitated SHOP Plans

The SHOP is the Small Business Health Options Program. It provides a way for small employers (50 or fewer employees) to purchase group health plan coverage through the Marketplace. Employers can offer a single health plan or a choice of any health plan within a specific metal tier. The SHOP handles much of the administrative work in enrolling employees in their selected options and in consolidating bills when multiple insurance carrier options are available.

As of January 1, 2017, a new employee choice option will be offered on the federally-facilitated SHOP. Under the new "vertical choice" model, employers will be able to offer employees a choice of all plans across all available levels of coverage from a single insurer. States can choose to opt out of offering vertical choice.

CONCLUDING THOUGHTS

Employers will need to be aware of these latest ACA updates. First, follow up with your vendors next year to confirm they are adopting the new SBC format, which applies to the first day of your first plan year on or after April 1, 2017. It also needs to be used during the annual enrollment period associated with that plan year. Since the effective date is over a year off for many plans, it may make sense to check three months prior to the renewal for your plan year on or after April 1, 2017.

Next, employers should update the affordability percentage when testing their lowest-value plan for affordability in 2017.

Finally, the Benefit and Payment Parameters for 2017 did not include many action items for employers. However, employers need to take note of the 2017 maximum out-of-pocket limits. Some plans set the limits at those allowed by law, and an increase will be permitted in 2017.

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