Proposed 2018 Benefit Payment and Parameters Rule

The Centers for Medicare & Medicaid Services (CMS) released a proposed rule for the 2018 Benefit Payment and Parameters and a fact sheet about the proposed rule. Among other items, the proposed rule provides updates and annual provisions relating to:

- Risk adjustments
- Cost-sharing parameters and cost-sharing reductions
- The Small Business Health Options Program (SHOP)
- Eligibility and appeals
- The Medical Loss Ratio (MLR) program

The Benefit Payment and Parameters rule is typically finalized in the first quarter of the year following the release of the proposed version. Comments on the proposed rule are due by October 6, 2016.

The 2018 open enrollment period will be November 1, 2017, to January 31, 2018.

Requirement Relating to Health Insurance Coverage

Definition of "Plan" and "Product": The rule proposes to revise the definition of "plan" and "product" so that a plan or product is considered the same plan or product when it is no longer offered by the same issuer, but is still offered by a different issuer in the same controlled group. The rule proposes that where the product has been modified, transferred, or replaced, the product will be considered to be the same product when it meets certain standards for uniform modification of coverage. The proposed rule includes examples of product network types in the definition of "product" such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, and indemnity.

Risk Adjustment Model Recalibration

Definition of "Large Employer": The rule proposes deleting the definition of "large employer" for purposes of risk adjustment. The rule proposes that, for the risk adjustment program, the issuer should use the employee counting method used to determine group size under state law, unless that counting method does not account for employees that are not full-time. If the state counting method does not take non-full-time employees into account, then the issuer should use the counting method under Section 4980H(c)(2) of the Internal Revenue Code. The rule proposes that, for the risk corridors program, the issuer should use the employee counting method used to determine group size under state law.

Accounting for Partial Year Enrollment: The rule proposes to recalibrate the adult 2017 and 2018 benefit year risk adjustment models to incorporate partial year enrollment duration factors. The rule proposes to allow for risk adjustment methodology to be developed by the Department of Health and Human Services (HHS) and published in rulemaking in advance of the benefit year.

Incorporating Prescription Drug Utilization: The rule proposes to incorporate a small number of prescription drug classes as predictors in the HHS risk adjustment methodology for the 2018 benefit year to impute missing diagnoses and to indicate illness severity.

High-Cost Risk Pool: Beginning for the 2018 benefit year, the rule proposes to create a pool of high-cost enrollees where an adjustment to issuers' transfers would fund 60 percent of costs where individual costs are above $2 million.

Risk Adjustment Data Validation: The rule proposes several amendments to the risk adjustment data validation process, including proposals related to the review of prescription drug data, random sampling for issuers below a certain size, and the establishment of a discrepancy and administrative appeals process.

Payment Parameters

FFM User Fee for 2018: The rule proposes to charge a Federally-facilitated Marketplaces (FFM) user fee rate of 3.5 percent of premium for the 2018 benefit year. This user fee rate is the same as the rate for each benefit year from 2014 through 2017. The rule proposes to charge issuers operating in a State-based Marketplace on the Federal platform (SBM-FP) a user fee rate of 3 percent of premium for the 2018 benefit year.

Premium Adjustment Percentage: For 2018, the rule proposes a premium adjustment percentage of approximately 16.17 percent, reflecting an increase of 2.6 percent from 2017.

Required Contribution Percentage: For purposes of the individual requirement to have minimum essential coverage each month, qualify for an exemption, or make a shared responsibility payment on a federal tax return, the rule proposes the 2018 required contribution percentage of 8.05 percent.

Annual Limitation on Cost Sharing: The maximum annual limitation on cost sharing is the product of the dollar limit for calendar year 2014 ($6,350 for self-only coverage) and the premium adjustment percentage for 2018, rounded down to the next lowest $50. The rule proposes a maximum annual limitation on cost sharing for 2018 of $7,350 for individual coverage and $14,700 for family coverage.

Cost Sharing: The requirement established in the 2017 Payment Notice that qualified health plan (QHP) issuers count an essential health benefit (EHB) provided by an out-of-network ancillary provider at an in-network facility toward the in-network annual limitation on cost sharing for QHPs in certain circumstances becomes applicable in benefit year 2018. That is, if a QHP enrollee received an EHB in an in-network setting, such as an in-network hospital, but the enrollee was charged out-of-network cost sharing for an EHB provided by an out-of-network ancillary provider, that cost sharing would apply toward the annual limitation on cost sharing.

Alternatively, the plan could provide a written notice to the enrollee stating that additional costs may be incurred for the EHB provided by an out-of-network ancillary provider in an in-network setting, including balance billing charges, unless such costs are prohibited under state law, and that any additional charges may not count toward the in-network annual limitation on cost sharing. This notice must be provided

within 48 hours prior to provision of the benefit or when the issuer would typically respond to a timely submitted prior authorization request. This alternative would not be available if the issuer does not meet the timeframe established in regulation. The rule proposes that this policy apply to QHPs, both on and off Exchanges, regardless of whether the QHP covers out-of-network services.

Stand-Alone Dental Plans (SADPs) Related to the Annual Limitation on Cost Sharing: Under the proposed rules, the annual limitation on cost sharing is established for plan years through 2018, and then indexed to the consumer price index (CPI) for dental services thereafter. The rule proposes maintaining the dental annual limitation on cost sharing at $350 for one child and $700 for two or more children.

Eligibility, Enrollment, and Benefits

Direct Enrollment: For the 2018 plan year and beyond, the rule proposes a number of requirements for web-brokers, agents and issuers.

- Web-brokers and issuers that use the direct enrollment pathway to differentially display standardized options when they facilitate enrollment through a Federally-facilitated Exchange (FFE) or a State-based Exchange on the Federal platform (SBE-FP) that has elected must implement differential display; however, the proposed rule does not require the manner of differentiation to be identical to the one adopted for displaying standardized options on HealthCare.gov.
- Web-brokers must display certain information relating to advance payments of the premium tax credits prominently and permit enrollees to select a particular advanced premium tax credit level, requirements that already apply to QHP issuers engaged in direct enrollment.
- Web-brokers must demonstrate operational readiness, including compliance with applicable privacy and security requirements, prior to accessing either the current or enhanced direct enrollment pathway.
- An agent or broker that assists with or facilitates enrollment of qualified individuals in a manner that constitutes enrollment through an FFE or SBE-FP, or assists individuals in applying for the advanced premium tax credit (APTC) and cost-sharing reductions for QHPs sold through an FFE or SBE-FP, must refrain from having a website that HHS determines could mislead consumers into believing they are visiting HealthCare.gov.
- Web-brokers – who provide access, through a contract or other arrangement, to their direct enrollment pathway to another agent or broker to help an applicant complete the QHP selection process – must be responsible for ensuring those websites are compliant.
- Web-brokers must engage in certain post-enrollment assistance activities. The rule proposes to allow third parties to perform monitoring and oversight over web-brokers to ensure compliance with the direct enrollment requirements.

The rule proposes to allow HHS to immediately suspend the agent or broker's ability to transact information with the Exchange as part of the direct enrollment pathway if HHS discovers circumstances that pose unacceptable risk to Exchange operations or its information technology systems.

Exchange Notices: The rule proposes to specify that electronic notices would be the default method for sending required SHOP Exchange notices, unless otherwise required by federal or state law. The proposed amendment would make mailed paper notices optional, at the election of the employer or employee, as applicable, unless other federal or state law would not permit this.

The rule proposes to give individual market exchanges and SHOPs flexibility to send notices through standard mail, instead of electronically, if an individual market exchange or SHOP is unable to send select notices electronically due to technical limitations, even if an election has been made to receive such notices electronically.

Special Enrollment Periods: The rule proposes to codify the following special enrollment periods:

- For dependents of Indians, as defined by Section 4 of the Indian Health Care Improvement Act, who are enrolled or are enrolling in a QHP through an exchange at the same time as an Indian.
- For victims of domestic abuse or spousal abandonment and their dependents who seek to apply for coverage apart from the perpetrator of the abuse or abandonment.
- For consumers and their dependents who apply for coverage and are later determined ineligible for Medicaid or CHIP.
- Enrollment triggered by material plan or benefit display errors on the exchange website, including errors related to service areas, covered services, and premiums.
- Enrollment triggered when a consumer resolves a data matching issue following the expiration of an inconsistency period.

Employer Appeals Process: The rule proposes to permit an employer appeals process to use paper-based processes to accept appeal requests, provide appeals notices, and securely transmit appeals-related information between entities, when the exchange appeals entity is unable to establish and perform otherwise required related electronic functions.

Enrollment Period Under SHOP: The rule proposes that qualified employers would be required to notify the SHOP about a newly qualified employee on or before the 30th day after the day that the employee becomes eligible for coverage. The rule proposes that SHOPs would be required to provide an employee who becomes a qualified employee outside of the initial or annual open enrollment period with a 30-day enrollment period that begins on the date the qualified employer notifies the SHOP about the newly qualified employee.

The rule proposes to eliminate the requirement that enrollment periods for newly qualified employees must end no sooner than 15 days prior to the date that any applicable employee waiting period longer than 45 days would end if the employee made a plan selection on the first day of becoming eligible.

The rule proposes to specify that the coverage effective date for a newly qualified employee would be the first day of the month following the plan selection, with some clarifications. The rule proposes to specify that: (1) if a newly qualified employee's waiting period ends on the first day of a month and the employee has already made a plan selection by that date, coverage would also be effective on that date; and (2) if a newly qualified employee makes a plan selection on the first day of a month and any applicable waiting period has ended by that date, coverage would be effective on that date.

The rule proposes to require that if a qualified employer with variable hour employees makes a regular, specified number of hours of service per period (or working full-time) a condition of employee eligibility for coverage offered through a SHOP, any measurement period that the qualified employer uses to determine eligibility (under Section 147.116(c)(3)(i) regarding prohibition on waiting periods that exceed 90 days) must not exceed 10 months (rather than the 12-month measurement period otherwise allowed).

The rule proposes that waiting periods in a SHOP may not exceed 60 days, calculated beginning on the date the employee becomes eligible, regardless of when the qualified employer notifies the SHOP about

the newly qualified employee. The rule proposes that a Federally-facilitated SHOP or a State-based SHOP that uses the Federal platform for SHOP eligibility or enrollment functions would only allow waiting periods of 0, 15, 30, 45, and 60 days.

The rule proposes to permit SHOP employer and employee eligibility appeals processes to use a secure and expedient paper-based process if the appeals entity cannot fulfill certain electronic requirements.

The rule proposes that issuers in all SHOP Exchanges must make their QHPs available for enrollment through the SHOP Exchange for the full plan year for which the plan was certified, unless a basis for suppression applies.

Currently, a QHP issuer is not required to provide notification to enrollees when it seeks but is denied certification for a subsequent, consecutive certification cycle by the Exchange. The rule proposes to require that QHP issuers provide such notice within 30 days of the date of an Exchange's denial of certification for a subsequent, consecutive certification cycle.

Market Reforms

Child Age Rating: The rule proposes updates to the child age rating structure. The rule proposes one age band for individuals age 0 through 14, and then single-year age bands for individuals age 15 through 20, effective for plan years or policy years beginning on or after January 1, 2018. The rule proposes child rating factors that, overall, are higher than the current child factor.

Reassessment of the Five-Year Ban on Market Reentry upon Withdrawal from a Market: The rule proposes several changes to the guaranteed renewability regulations that would address instances where issuers may inadvertently trigger a market withdrawal and five-year ban on market reentry. The rule proposes, for purposes of guaranteed renewability, that a non-grandfathered product may be considered the same product when offered by a different issuer within an issuer's controlled group, provided it otherwise meets the standards for uniform modification of coverage.

The rule proposes to permit issuers to replace their entire portfolio of products without triggering the five-year ban under the market withdrawal provision when an issuer replaces its entire portfolio of products in a market with products that are different in ways that are not within the scope of uniform modifications, provided the issuer reasonably identifies which newly offered product replaces which discontinued product and subjects the new product to the federal rate review process (to the extent applicable to coverage of the same type and in the same market) as if it were the same product as the discontinued product it replaces.

An issuer's identification of which new product replaces which discontinued product would be considered reasonable if it reflects the issuer's expectations regarding significant transfer of enrollment from one product to the other (for example, because the products have been crosswalked for auto-reenrollment).

The rule proposes to provide that an issuer has not discontinued offering all health insurance coverage in a market if a member of the issuer's controlled group continues to offer and make available for enrollment at least one product of the original issuer that is considered to be the same product.

Medical Loss Ratio (MLR) Rebate Reporting for New and Growing Issuers: The rule proposes to expand the MLR provision allowing issuers to defer reporting of policies newly issued with a full 12 months of experience (rather than policies newly issued and with less than 12 months of experience) in that MLR reporting year and to limit the total rebate liability payable with respect to a given calendar year in certain situations.

Federal agencies also published the proposed 2018 actuarial value calculator and its methodology.

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