ACA COMPLIANCE BULLETIN

PROPOSED NOTICE OF BENEFIT & PAYMENT PARAMETERS FOR 2018

HIGHLIGHTS

- For 2018, the ACA's out-of-pocket maximum would increase to $7,350 for self-only coverage and $14,700 for family coverage.
- The proposed rule would decrease the required contribution percentage for the affordability exemption from the individual mandate in 2018.
- The proposed rule would establish three new sets of standardized plan options in the individual market federal Exchanges.

IMPORTANT DATES

2018 Benefit Year

When finalized, the changes included in the proposed rule would generally be effective for the 2018 benefit year.

OVERVIEW

On Aug. 29, 2016, the Department of Health and Human Services (HHS) released its **proposed Notice of Benefit and Payment Parameters for 2018**. This proposed rule describes benefit and payment parameters under the Affordable Care Act (ACA), applicable for the 2018 benefit year, including updated standards relating to:

- Annual limitations on cost-sharing;
- The individual mandate's affordability exemption; and
- Special enrollment periods in the Exchange.

The rule would also enhance standards for state-based Exchanges on the federal platform (SBE-FPs) and create three new sets of six standardized benefit plan options in the federally facilitated Exchange (FFE).

ACTION STEPS

HHS may make changes to the proposed rule before finalizing it. However, the proposed rule is a good indicator of benefit and payment parameters that HHS may adopt for 2018.

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Annual Limitations on Cost-sharing

Effective for plan years beginning on or after Jan. 1, 2014, the ACA requires non-grandfathered plans to comply with an overall annual limit—or an out-of-pocket maximum—on essential health benefits (EHB).

The ACA requires the out-of-pocket maximum to be updated annually based on the percent increase in average premiums per person for health insurance coverage.

- For 2016, the out-of-pocket maximum is **$6,850 for self-only coverage** and **$13,700 for family coverage**.
- For 2017, the out-of-pocket maximum is **$7,150 for self-only coverage** and **$14,300 for family coverage**.
- Under the proposed rule, the out-of-pocket maximum would increase for 2018 to **$7,350 for self-only coverage** and **$14,700 for family coverage**.

Under the proposed rule, the required contribution percentage used to determine eligibility for an exemption from the individual mandate would decrease to 8.05 percent in 2018.

Individual Mandate's Affordability Exemption

Under the ACA, individuals who lack access to affordable minimum essential coverage (MEC) are exempt from the individual mandate penalty. For purposes of this exemption, coverage is considered affordable for an employee if the required contribution for the lowest-cost, self-only coverage does not exceed **8 percent of household income**.

This required contribution percentage is adjusted annually after 2014, as follows:

- For 2015, the required contribution percentage is **8.05 percent of household income**.
- For 2016, the required contribution percentage is **8.13 percent of household income**.
- For 2017, the required contribution percentage is **8.16 percent of household income**

Under the proposed rule, the required contribution percentage would **decrease in 2018**. The proposed rule would provide that, for 2018, an individual is exempt from the individual mandate penalty if he or she must pay more than **8.05 percent of his or her household income** for MEC.

Exchange Special Enrollment Periods

Under the Exchanges, certain special enrollment periods are available to ensure that people who lose health insurance during the year, or who experience other qualifying events, have the opportunity to enroll in coverage. The proposed rule would also amend the provisions relating to special enrollment periods in the individual market in an effort to clarify the requirements and limit abuse.

Due to growing concerns over abuse of these rules, HHS recently added warnings on www.healthcare.gov about inappropriate use of special enrollment periods, eliminated special enrollment periods that are no

longer needed and enhanced eligibility rules. The proposed rule requests comments on how to balance these concerns over abuse with the risk of creating barriers to enrollment for legitimately eligible individuals.

In addition, the proposed rule would also codify the following existing special enrollment periods, in an effort to provide clarity and certainty with regard to these rules:

- The special enrollment period for dependents of Indians who are enrolled (or are enrolling) in a QHP through an Exchange at the same time as an Indian;
- The special enrollment period 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;
- The special enrollment period for consumers (and their dependents) who apply for coverage and are later determined ineligible for Medicaid or CHIP;
- The special enrollment period that may be triggered by material plan or benefit display errors on the Exchange website (including errors related to service areas, covered services and premiums); and
- The special enrollment period that may be triggered when a consumer resolves a data matching issue following the expiration of an inconsistency period.

Enhanced Standards for State-based Exchanges on the Federal Platform

The final rule Notice of Benefit and Payment Parameters for 2017 added an additional Exchange model—**a state-based Exchange on the federal platform (SBE-FP)**—to enable SBEs to conduct certain processes using the federal eligibility and enrollment technology infrastructure on www.healthcare.gov. The 2017 final rule required SBE-FPs to enforce certain plan and issuer requirements that are no less strict than the requirements that HHS applies in the FFEs.

The 2018 proposed rule would enhance this obligation, requiring SBE-FPs that use the federal platform for certain SHOP functions to establish standards and policies consistent with certain FF-SHOP requirements. Specifically, affected SBE-FPs must establish compliant standards and policies with respect to:

- Premium calculation, payment and collection requirements;
- The timeline for rate changes;
- Minimum participation rate requirements and calculation methodologies;
- Employer contribution methodologies;
- Annual employee open enrollment period requirements;
- Initial group enrollment or renewal coverage effective date requirements; and
- Termination of SHOP coverage or enrollment rules.

Standardized Exchange Plan Options

The final Notice of Benefit and Payment Parameters for 2017 established six standardized benefit plan options—called "**Simple Choice plans**"—in the individual market FFE, in order to simplify the plan selection process by allowing consumers to more easily compare plans across issuers in the FFE. These standardized options include:

- One bronze standardized option;
- One silver standardized option;
- A separate standardized option for each silver plan variation (73 percent, 87 percent and 94 percent) available to individuals who are eligible for cost-sharing reductions; and
- One gold standardized option.

For 2018, the proposed rule would provide the following **three new sets of six standardized options**:

- The first set of standardized options would be a version of the 2017 standardized plan options that have been updated to reflect modifications for 2016 enrollment weighted QHPs.
- The second set of standardized options is designed to work in states that: (1) require that cost-sharing for physical, occupational or speech therapy be no greater than the cost-sharing for primary care visits; (2) limit the amount that can be charged for each drug tier; or (3) require that all drug tiers carry a copayment rather than coinsurance.
- The third set of standardized options is designed to work in states with maximum deductible requirements and other cost-sharing standards.

Like the 2017 standardized options, the proposed 2018 standardized options would each have a single provider tier, a fixed in-network deductible, a fixed annual cost-sharing limit and a fixed copayment or coinsurance for a key set of EHB that comprise a large percentage of the total allowable costs for an average enrollee. However, the proposed rule includes the following changes, intended to comply with state law requirements on cost-sharing:

- The proposed 2018 options at the **silver**, **silver cost-sharing reduction variations** and **gold** levels of coverage would have separate medical and drug deductibles; and
- The proposed standardized options at the **silver 87 percent cost-sharing reduction plan variation**, **silver 94 percent cost-sharing reduction plan variation** and **gold** levels of coverage have a $0 drug deductible (meaning no deductible applies to the drugs).

Each state would still only have one standardized option at each level of coverage. In addition, the proposed rule would also establish a **standardized health savings account (HSA)-eligible bronze high-deductible health plan (HDHP) option** that would comply with IRS HSA rules.

Child Age Rating

The ACA allows premium rates to vary based on age within a ratio of 3 to 1 for adults. In addition, the ACA provides for uniform age bands, including a single age band for individuals age 0 through 20. However, this age rating structure for children has proved to be problematic, particularly when individuals reach age 21 (often resulting in significant premium increases at that time).

The proposed rule would update the child age rating structure in an effort to better reflect the health risk of children and to provide a more gradual transition when individuals move from age 20 to 21. Specifically, effective for plan or policy years beginning on or after Jan. 1, 2018, the proposed rule would establish:

- ✓ One age band for individuals age 0 through 14; and
- ✓ Single-year age bands for individuals age 15 through 20.

In addition, the proposed rule would establish child rating factors that, overall, are higher than the current child factor, and are intended to more accurately reflect health care costs for children.

Source: Department of Health & Human Services