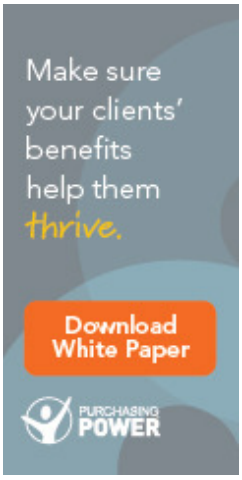
WASHINGTON UPDATE

September 2, 2016



CMS Releases 2018 Marketplace Rule and New Actuarial Value Calculator

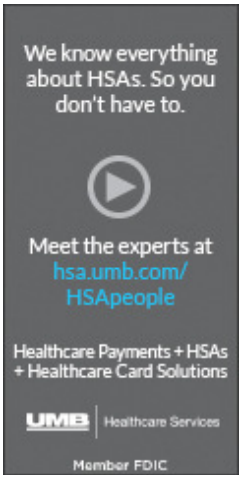
On Monday, the Centers for Medicare and Medicaid Services (CMS) released the proposed 2018 Notice of Benefit and Payment Parameters. The 294-page proposed regulation provides guidance on both individual and SHOP marketplaces requirements, changes to the risk adjustment programs for 2017 and 2018, participation requirements for bronze, silver and gold plans, network requirements, special enrollment periods, direct enrollment, and numerous other issues. In addition to the marketplace rule, the administration concurrently released a draft actuarial value calculator and methodology for 2018.

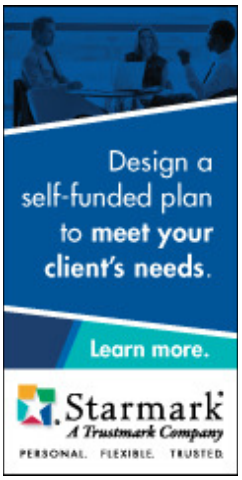
Agents and Brokers

- Require agents and brokers to support post-enrollment activities to effectuate enrollment through the marketplace, including data-match and eligibility issues.
- Require web-brokers to display standardized plans when facilitating marketplace enrollment, similarly to Healthcare.gov, or receive approval to display differently.
- Allow web-brokers to utilize enhanced direct enrollment by allowing consumers to remain on web-broker's websites. Eligibility determination information would be passed through Healthcare.gov then back to the consumer through the web-broker's website. CMS is seeking comments on privacy and security issues.
- Require web-brokers to prominently display information relating to tax credits and cost-sharing eligibility directly on their websites.
- Require web-brokers to allow consumers to accept an amount less than their full eligible tax credit to account for potential future income increases.
- Allow web-brokers serving more than one state to aggregate their limited English proficient population across all states that they serve to determine the 15 languages needed to provide taglines.
- Suspend agent/broker access for direct enrollments if agent/broker poses risks to the marketplace or information systems, such as using technology not approved by CMS.
- Prohibit agents and brokers from maintaining websites with URLs or appearances similar to Healthcare.gov that may mislead consumers to believe they are applying through the marketplace.

Medical Loss Ratio (MLR)

- Allow insurers the option of calculating MLR liability for a single year, if the insurer recalculates liability for two subsequent years instead of the existing three-year rolling average.
- Encourage more plans by allowing deferral of reporting of new business when up to half of their premium is attributable to policies with 12 months or less.





Special Enrollment Periods (SEPs)

- Seeking comments and data addressing issues where healthier consumers are discouraged from enrolling in SEPs due to additional verification requirements.
- Codify SEPs provided under previous guidance, including: dependents of American Indians; victims of domestic abuse or spousal abandonment and their dependents; consumers incorrectly denied subsidies due to wrongly being deemed eligible for Medicaid or CHIP; consumers disadvantaged by material plan or benefit display errors, including errors related to service areas, covered services or premiums; and consumers who resolve data matching issues after the expiration of an inconsistency period or have income below 100% of the federal poverty level and did not enroll in coverage while waiting for the Department of Health and Human Services (HHS) to verify lawful status.

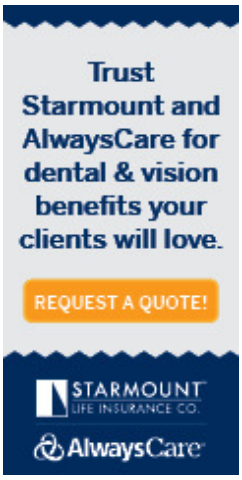
Age-Rating, User Fees, Formulas and Limits

- Expand age-rating bands for children ages 0-20 from the current single-age band with a default age factor of .635 to an age factor for children up to age 14 of .635 to .765. This would gradually increase from ages 15-20. States would continue to be able to set their own age rating curves if they chose. CMS is seeking comments on whether to phase this in or switch all at once.
- Again set the marketplace user fee at 3.5% of premiums. CMS is seeking comments on whether a portion of this fee should be directed to outreach and education.
- Increase the user-fee for insurers using the state-based exchange on the federal platform from 1.5% to a 3%, with potential for this to be phased-in.
- Increase the exemption from the individual mandate from 8.0% to 8.05% of household income.
- Increase the maximum annual limit for cost sharing to $7,350 for self-only coverage and $14,300 for other than self-only coverage. Cost-sharing reductions would reduce this to $2,450 for self-only and $4,900 for other than self-only for those with incomes below 200% of poverty, and $5,850 for self-only and $11,700 for other than self-only for those between 200-250% of poverty.
- Increase the annual limit on cost sharing for standalone dental plans to $350 for one child and $700 for two or more children.

Risk Adjustment

- Clarify that insurers should use state law counting methods to determine whether an employer is a small or large employer for purposes or risk adjustment, as long as state law accounts for non-full time employees.
- Modify the risk adjustment formula to account for partial-year enrollments.
- Incorporate prescription drug utilization to identify high-risk conditions.
- Calculate the total amount of claims paid for high cost enrollees (those with costs exceeding $2 million), with those insurers reinsured through the risk adjustment program for 60% of excess cost.
- Base the risk adjustment user fee on billable member months instead of enrollee member months, replacing the annual fee from $1.56 per enrollee per year with $1.32 per billable enrollee per year.
- Reduce the amount of risk adjustment funds collected from insurers by 7.1% for 2017 before payments are made to insurers.

SHOP



IN THIS ISSUE

TOOLS

- Eliminate existing "tying" provision that requires insurers selling on the individual market to have at least a 20% share of the small group market in the state, as measured by earned premium, and to offer at least one silver and one gold plan on the SHOP.
- Seeking comments on eliminating enrollment through the federal SHOP if the SHOP becomes unviable. Enrollments would instead be made through web-brokers and third-party administrators.
- Require that waiting periods in the SHOP to not exceed 60 days, beginning with the date an employee becomes eligible. The measurement period for a variable hour employee eligible for SHOP coverage cannot exceed 10 months.
- Require state-based exchanges on the federal platform that use federal SHOP to establish standards and policies consistent with the federal SHOP, including for: premium calculation, payment, and collection requirements; rate change timelines; minimum participation rate requirements and calculation methodologies; employer contribution methodologies; annual employee open enrollment periods; initial group enrollment or renewal coverage effective dates; and termination of SHOP coverage or enrollment rules.

Standardized Plans

- Standardized plans for 2018 would have a single provider tier, fixed deductible, fixed annual cost-sharing limit, and fixed copayment or coinsurance obligations for a key group of essential health benefits. The 2018 silver, silver cost-sharing variation, and gold plans would have separate medical and drug deductibles, and the 87% and 94% silver cost-sharing variations and gold plans have $0 drug deductibles.
- Include a bronze high-deductible health plan compliant option that would allow an enrollee to qualify for a tax-subsidized health savings account.
- Establish three sets of six standardized plans. First set would be a version of the 2017 plans. The second set would be designed to work in states that: 1) require that cost sharing for physical, occupational, or speech therapy be not greater than cost sharing for primary care visits; 2) limit the amount charged for each drug tier; or 3) require that drug tiers have copayments rather than coinsurance. The third set is designed for states that have maximum deductible requirements or other cost-sharing standards.

Network Adequacy

- Reaffirm requirement that insurers notify enrollees at least 48 hours before a procedure if the enrollee might receive service from an out-of-network ancillary provider while at an in-network facility.
- Require insurers cover a percentage of essential community providers in its service area, including multiple providers counting as a single essential community provider.

Market Withdrawal from Insurers

- Allow insurers to avoid the current five-year reentry ban if the insurer transferred all of its products to a related insurer under a corporate reorganization but maintained continuity of coverage within products in compliance with uniform modification of coverage standards. States with different rules governing market withdrawal could continue to use their own rules.

Actuarial Value (AV) and Calculator

- Provide more flexibility for insurers to meet bronze plan requirements by expanding the current "de minimum" from +/-2% to between -2% and +5% when the positive variance is used to

cover major services before the deductible or to establish HDHP eligibility.

- Updates to the AV Calculator:
  - Use of data from HMO and EPO plans in addition to PPO and POS plans
  - Use of 2015 claims data instead of pre-ACA claims data
  - Modified trend factors for trending forward 2015 claims, using a 3.5% annual trend factor for medical claims and a 11.5% factor for drug claims
  - The ability to enter a plan design with a copayment for an outpatient facility fee and outpatient physician/surgical services
  - A modification to improve the functionality of calculation of plans with separate deductibles and combined maximum out-of-pocket limits
  - The possibility of including bronze plans with the expanded de minimis range allowed by the 2018 payment rule.

| **Next** Article >

1212 New York Ave NW, Ste 1100 Washington, DC 20005
Ph. 202.552.5060 Fax 202.747.6820 www.nahu.org

National Association of Health Underwriters