TRP Health Policy

**Memorandum**

*Aug. 29, 2016*

# CMS ISSUES CY 2018 NOTICE OF BENEFIT AND PAYMENT PARAMETERS PROPOSED RULE; ACA RISK ADJUSTMENT ADDRESSED

Today, the Centers for Medicare and Medicaid Services (CMS) released the **Calendar Year (CY) 2018 Notice of Benefit and Payment Parameters (NBPP)** **proposed rule**.

- **What it is.** The wide-ranging annual Exchange rule addresses Affordable Care Act (ACA) risk adjustment and an array of policies affecting Qualified Health Plans (QHPs).

- **Why it is important for you.** CMS makes proposals in a range of areas, including network breadth, essential community providers, and the ACA risk adjustment program. The proposals come as stakeholders discuss the status of insurers' participation in Exchanges, high-profile exits from some Exchanges, and the impact on market competition.

- **Potential next steps.** The policies generally take effect for the 2018 plan years, although some may begin sooner. Comments are due within 30 days of *Federal Register* publication, placing the deadline on or around Oct. 6, a signal that the Administration plans to finalize the regulation before leaving office. Typically NBPP proposals are made in November and finalized the following March.

Highlights include:

- **Risk Adjustment Model Recalibration** – CMS proposes a variety of changes to ACA risk adjustment:
  - ***Partial Year Enrollees*** – As previously signaled, CMS proposes to incorporate partial-year adjustment factors into the adult risk adjustment model for the adult 2017 and 2018 benefit year risk adjustment models. See a discussion beginning on p. 49.
  - ***Prescription Drug Utilization*** – CMS proposes to incorporate prescription drug utilization data into risk adjustment models beginning with the 2018 benefit year. See p. 54-55. Specifically, Table 2 on p. 63 lists the 11 drug-diagnosis (RXC-HCC) pairs that CMS is proposing to incorporate into the adult models for the 2018 benefit year, including hepatitis C antivirals, HIV/AIDS antivirals, immune suppressants and immunomodulators, MS agents, and others. CMS says "we intend to evaluate the effects of this change to determine whether to continue, broaden, or reduce this set of factors in the HHS risk adjustment models."
  - ***High-Cost Risk Pool*** – CMS proposes to "create a pool of high-cost enrollees where an adjustment to issuers' transfers would fund 60 percent of costs where individual



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costs are above $2 million." See a discussion beginning on p. 64 of the public inspection copy.

CMS seeks comment on approaches to addressing the risk model's "underprediction of risk for low cost enrollees," according to feedback it has received (see p. 68), and discusses possible options. CMS proposes to release final 2018 benefit year coefficients prior to 2018 benefit year risk adjustment calculations, leveraging the most recent MarketScan data. It notes the coefficients most likely will be released in early spring 2019. For future model recalibration, CMS proposes to use EDGE server data to recalibrate the model beginning for the 2019 benefit year.

The agency also makes several proposals regarding risk adjustment data validation, addressing "review of prescription drug data, random sampling for issuers below a certain size, and the establishment of a discrepancy and administrative appeals process," CMS notes.

- **Pre-Existing Condition Insurance Program** – The agency seeks comment on ensuring that PCIP program enrollees successfully transition to Exchanges without having their coverage lapse, including using leftover PCIP funds to facilitate such transitions (see p. 42-43).

- **De Minimis Range for Bronze Plans** – CMS proposes a broader De Minimis range for the actuarial value of bronze plans when the plan covers services before application of the deductible. See a discussion beginning on p. 189 of the proposal's public inspection copy.

- **Standardized Options** – Following last year's establishment of standardized plan options (also known as Simple Choice plans), CMS proposes updated options based on new data. In addition, CMS proposes a larger number of standardized options in recognition of state cost-sharing laws. CMS says it made the proposal "with the intent that at least one standardized option in each level of coverage will comply with State requirements." Options include a "standardized health savings account-eligible bronze high-deductible health plan option that would comply with IRS Health Savings Account rules." CMS says that each state would still only have one standardized option at each level of coverage. See p. 124.

- **Network Breadth** – This year CMS will pilot a network breadth indicator in a number of States on HealthCare.gov to denote a QHP's relative network coverage. For the 2018 plan year, CMS proposes to "to incorporate more specificity into these indicators by identifying for consumers whether a particular plan is offered as part of an integrated provider delivery system." In addition, CMS seeks comment on "whether there are additional steps we can take to limit surprise bills for consumers." On p. 199 of the proposal CMS clarifies that if the policy is finalized, it would provide additional details in the 2018 Letter to Issuers in the Federally-facilitated Marketplace.

- **Essential Community Providers (ECPs)** – CMS proposes to "continue the 2017 benefit year calculation methodology that a plan applying for QHP certification to be offered through a Federally-facilitated Exchange must demonstrate in its QHP application that its network includes as participating providers at least a minimum percentage, as specified by HHS, of available ECPs in each plan's service area, with multiple providers at a single location counting as a single ECP toward both the available ECPs in the plan's service area and the issuer's satisfaction of the ECP participation standard." See additional proposals on p. 201 regarding continued 2017 benefit year calculations.

Additionally, CMS notes that it is considering changes to the counting of hospital ECPs for the 2019 benefit year and seeks comment on the best approach for measuring hospital participation.

- **Special Enrollment Periods (SEP)** – CMS proposes to codify certain SEPs that are already in place to "ensure the rules are clear and to limit abuse." Additionally, CMS seeks comment on policies that would help individuals enroll but also prevent abuse by ineligible persons. See p. 163.

- **Direct Enrollment** – CMS proposes that direct enrollment entities "must demonstrate operational readiness and compliance with certain requirements prior to their Web sites being used to complete QHP selection." Such entities, usually web brokers and issuers, will also have to provide a differential display of standardized options. Applying standards already in place for QHP issues, web brokers who directly enroll will have to "display certain information relating to advance payments of the premium tax credits prominently, and permit enrollees to select a particular APTC level." See a discussion on p. 221.

- **Binder Payments** – CMS proposes "to give Marketplaces the discretion to allow issuers to implement a reasonable extension of the binder payment deadlines when an issuer is experiencing billing or enrollment problems due to high volume or technical errors." See a discussion on p. 236.

- **Payment Parameters –** Highlights of CMS' proposed payment parameter policies include:

    - ***FFM and SBE-FP User Fees –*** CMS proposes to set the 2018 Federally-facilitated Marketplaces (FFM) issuer user fee rate at 3.5 percent – the same rate that has been assessed on FFE issuers over the 2014-2017 benefit year period. CMS seeks comment on a number of issues related to the FFM user fee rate, including whether the agency "should expressly designate a specific portion or amount of the FFE user fee to be allocated directly to outreach and education activities, recognizing the need for HHS to continue to adequately fund other critical Exchange operations such as the call center, HealthCare.gov, and eligibility and enrollment activities."

      In addition, CMS proposes to charge a user fee rate of 3 percent – up from the 1.5 percent of premiums charged delineated in the 2017 Payment Notice (a transition year) – to issuers offering Qualified Health Plans (QHPs) through a State-based Exchange on the Federal platform (SBE-FP) for the 2018 benefit year. CMS notes that it "intend[s] to review the costs incurred to provide these special benefits each year, and revise the user fee rate for issuers in the FFEs and SBE-FPs accordingly in the annual HHS notice of benefit and payment parameters."

    - ***Premium Adjustment Percentage and Annual Cost-sharing Limits –*** CMS proposes the 2018 premium adjustment percentage to be roughly 16.2 percent – up about 2.6 percent from 2017. This factor measures premium growth for a calendar year and is based on projections of average per enrollee employer-sponsored insurance (ESIs) premiums. Based on the 2018 premium adjustment percentage, coupled with 2014 maximum annual limitation on self-coverage cost-sharing ($6,350), CMS proposes certain cost-sharing parameters for 2018, namely: $7,350 for self-only coverage and

$14,700 for family coverage – about a 2.8 percent increase over last year's cost-sharing parameters ($7,150 for self-only coverage and $14,300 for family coverage). For stand-alone dental plans (SADPs), the dental annual limitation on cost-sharing for 2018 is $350 for one child and $700 for one or more children.

- **Child Age Rating** – CMS proposes updates to the child age rating structure, noting that it seeks to "better reflect the health risk of children and to provide a more gradual [premium] transition when individuals move from age 20 to 21." The proposal would take effect for plan or policy years beginning on or after Jan. 1, 2018. The proposal involves a single age band for children ages 0 through 14 and then single-year age bands for children ages 15 through 20. It also includes proposed child rating health factors that, CMS notes, "overall, are higher than the current child factor and more accurately reflect health care costs for children."

- **New Issuers** – Noting its desire to remove obstacles to issuer "entrance, growth, and innovation," CMS seeks comment on "whether we should eliminate a requirement that certain issuers participating in the individual market Federally-facilitated Marketplaces also offer coverage through the Federally-facilitated SHOP Marketplaces."

- **Medical Loss Ratio (MLR)** – CMS proposes expanding 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."

- **Guaranteed Renewability** – CMS proposes changes to applicable regulations so that:
  - "[F]or purposes of guaranteed renewability, 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"; and
  - "An issuer may replace all of its existing products with new products without triggering a [five-year ban associated with] market withdrawal, as long as the issuer matches new products with existing products for purposes of rate review."

- **Medicare-Individual Market Coordination of Benefits** – CMS seeks input on QHP policy provisions that pay secondary to Medicare for those who are Medicare enrolled or could be Medicare enrolled, though are not currently covered. The agency also seeks comments on "whether a legal basis exists to treat coordination of benefit provisions that relate to coverage in the individual market for Medicare beneficiaries differently for Medicare beneficiaries who are entitled to benefits under Medicare Part A and eligible to enroll under Part B under the [applicable] ESRD provisions." See p. 41.

Also today, CMS posted the draft 2018 Actuarial Value Calculator (Excel file).

A blog post from Marketplace CEO Kevin Counihan is available here. Also see CMS' fact sheet here and press release here. We hope this is helpful information. Please do not hesitate to reach out to us with any questions.