Final HHS Notice of Benefit and Payment Parameters for 2018
Fact Sheet

The HHS Notice of Benefit and Payment Parameters for 2018 final rule released today establishes standards for issuers and each Health Insurance Marketplace℠[1], generally for plan years that begin on or after January 1, 2018. The Marketplaces continue to play an important role in fulfilling one of the Affordable Care Act's core goals: reducing the number of uninsured Americans by providing access to affordable, quality health insurance. The Marketplace provides health insurance coverage to more than 10 million Americans, and we continue to see a strong demand for the quality, affordable coverage it offers.

The policies in this final rule include updates to the risk adjustment program that will strengthen its ability to protect consumers' access to high-quality, affordable options in the individual and small group markets, as well as other changes that will streamline the Marketplace consumer experience and strengthen the Marketplaces' individual and small group markets as a whole. The policies in this final rule build on other actions CMS has taken to strengthen the Marketplaces in recent weeks and months including an interim final rule addressing concerns about third party payments of premiums[2] and a pilot that will test whether pre-enrollment verification of special enrollment periods strengthens the Marketplace risk pool while maintaining access to coverage.[3]

This fact sheet summarizes key policies in the final rule.

Updates to the Risk Adjustment Model

Accounting for Partial Year Enrollment: We are finalizing the incorporation of partial year adjustment factors in the adult risk adjustment model to address feedback that the existing model under predicts claims costs for enrollees who are enrolled for only part of the year. We are incorporating the partial year adjustment factors in the adult 2017 and 2018 benefit year risk adjustment models, as we notified issuers of our intent to propose the change in prior guidance, and provided significant detail on the incorporation of an adjustment factor to account for partial year enrollment beginning with the 2017 benefit year.[4]

Incorporating Prescription Drug Utilization: We are finalizing the use of prescription drug utilization data to improve the predictive ability of our risk adjustment models beginning for the 2018 benefit year. By using prescription drugs to impute missing diagnoses and to indicate the level of severity of a health condition, we will better account for the health risk associated with insuring individuals with certain serious health conditions.

High-Cost Risk Pool: We proposed to incorporate into the risk adjustment methodology a high-cost risk pool calculation. This would exclude a percentage of costs above a threshold level in the calculation of

[1] Health Insurance Marketplace℠ and Marketplace℠ are service marks of the U.S. Department of Health & Human Services.
[2] Available https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-30016.pdf?utm_campaign=pi%20subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email
[3] For more information of the process, see https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Pre-Enrollment-SEP-fact-sheet-FINAL.PDF
[4] Available https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-08.html

enrollee-level plan liability risk scores so that risk adjustment factors would be calculated for risk associated with hierarchical condition category (HCCs) and prescription drug categories (RXCs) excluding these extreme costs. We are finalizing the creation of a pool for high-cost enrollees where an adjustment to issuers' transfers would fund 60 percent of an issuer's costs for individuals with claims above $1 million.

Administrative Costs in Transfer Formula: We are finalizing an adjustment to reduce the calculation of statewide average premium used in the risk adjustment transfer formula by 14 percent to account for fixed administrative costs beginning for the 2018 benefit year. This will allow for risk adjustment transfers to be calculated based on the portion of statewide average premiums that reflects enrollees' risk and not fixed administrative costs.

Publication of Final Coefficients: We are finalizing the proposal to issue final 2018 benefit year coefficients through guidance prior to the 2018 benefit year risk adjustment calculations using the 2013, 2014, and 2015 MarketScan® data, in the early spring of 2017, prior to rate setting.

Future Recalibration: We are finalizing the proposal to use data from external data gathering environment (EDGE) servers, the systems issuers use to submit data for the risk adjustment and reinsurance programs, to recalibrate the risk adjustment models beginning for the 2019 benefit year. Using the EDGE server data would better reflect risk adjustment covered plans for model recalibration. We will use a masked enrollee-level dataset from the EDGE server to recalibrate the risk adjustment models, and inform development of the Actuarial Value Calculator and risk adjustment methodology, which HHS releases annually. The dataset would use masked enrollee IDs, and would not include information such as the geographic rating area, state, plan ID, issuer ID, or the EDGE server.

Risk Adjustment Data Validation: We also finalize several updates 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: We are finalizing a Federally-facilitated Marketplaces (FFM) user fee rate of 3.5 percent of premiums for the 2018 benefit year. This user fee rate is the same as the rate for each year from 2014 through 2017 benefit years. The final rule will charge issuers operating in a State-based Marketplace on the Federal platform (SBM-FP) a user fee rate of 2 percent of premiums for the 2018 benefit year. We are also allocating at least 3 percent of user fees to outreach and education to support services provided to Marketplace issuers and robust enrollment in the Marketplace.

Premium Adjustment Percentage: This percentage generally measures the average health insurance premium increase since 2013, based on the most recent National Health Expenditures Accounts projection of per enrollee employer-sponsored insurance premiums. The premium adjustment percentage is used to set the rate of increase for three key parameters: the maximum annual limitation on cost sharing, the required contribution percentage for eligibility for a certain exemptions under section 5000A of the Internal Revenue Code (the Code), and the affordability percentage for calculation of assessable payment amounts under section 4980H(a) and (b) of the Code. For 2018, we are finalizing a premium adjustment percentage of approximately 16.17 percent, reflecting an increase of 2.6 percent

from 2017.

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 lower $50. We are finalizing a maximum annual limitation on cost sharing for 2018 of $7,350 for individual coverage and $14,700 for family coverage.

Annual limitation on cost sharing for stand-alone dental plans (SADPs) that provide pediatric benefits: For plan years 2018 and after, the annual limitation on cost sharing for stand-alone dental plans that cover pediatric dental essential health benefits (EHB) and that are certified by a Marketplace is established by a formula indexed to the consumer price index (CPI) for dental services. This rule uses the existing formula to maintain the annual limitation on cost sharing for SADPs that provide pediatric EHB and that are certified by a Marketplace at $350 for one child and $700 for two or more children for plan years beginning in 2018.

Plan Benefits

Bronze Plans: To permit greater flexibility in cost sharing design and to accommodate potential future updates to the Actuarial Value Calculator, we are finalizing an allowance for a broader de minimis range for the actuarial value of bronze plans when the plan covers at least one major service, other than preventive services, before application of the deductible or is a high deductible health plan (HDHP).

Standardized Options (Simple Choice plans): In the 2017 Payment Notice, we finalized six standardized options (also now referred to as Simple Choice plans), one at each of the bronze, silver, silver cost-sharing reduction variation, and gold levels of coverage based on analysis of 2015 enrollment- weighted FFM qualified health plan (QHP) data. For 2018, we are finalizing updated standardized options, based on a similar analysis of enrollment-weighted 2016 individual market FFM QHP data and also SBM-FP QHP data. Additionally, recognizing that issuers in some States were unable to offer standardized options in 2017 due to state-specific cost-sharing requirements, we are finalizing three sets of standardized options and selecting one standardized option at each level of coverage for each State based on that State's cost-sharing requirements. Each State will still only have one standardized option at each level of coverage. We are also finalizing one high-deductible health plan option at the bronze level of coverage that issuers may choose to offer as long as the plan does not conflict with State cost-sharing laws.

Network Breadth: In the 2017 Payment Notice, HHS finalized a policy to provide information about QHP network breadth on HealthCare.gov, in order to assist consumers with plan selection. For the 2017 benefit year, we have implemented a pilot of the network breadth indicator in 4 States (Maine, Ohio, Tennessee, and Texas) on HealthCare.gov to denote a QHP's relative network coverage. For the 2018 plan year, we finalized a policy 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.

Eligibility, Enrollment, and Benefits

Special Enrollment Periods: We are codifying several special enrollment periods that are already available to consumers through the FFM in order to ensure the rules are clear and to limit misuse.

Direct Enrollment: We are finalizing a number of additional consumer protections around the direct enrollment channel, though which web-brokers and issuers may assist consumers with enrollments through an Exchange using a non-Exchange website. For instance, we are finalizing that direct enrollment entities must demonstrate operational readiness and compliance with certain requirements prior to their non-Exchange Web sites being used to complete QHP selection, and provide differential display of standardized options. We are also finalizing a provision requiring web-brokers to display certain information relating to advance payments of the premium tax credits (APTC) prominently, and to permit enrollees to select a particular APTC level, requirements that already apply to QHP issuers engaged in direct enrollment. Additionally, we are also finalizing a proposal to allow third parties to perform monitoring and oversight over web-brokers, to ensure compliance with our direct enrollment requirements.

Binder Payments: We are finalizing our proposal 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.

Market Reforms

Child Age Rating: We are finalizing updates to the child age rating structure to better reflect the health risk of children and to provide a more gradual transition when individuals move from age 20 to 21. Specifically, we establish 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. We are finalizing child rating factors that, overall, are higher than the current child rating factor and more accurately reflect health care costs for children.

Reassessment of the 5-Year Ban on Market Reentry upon Withdrawal from a Market: We are finalizing several changes to the guaranteed renewability regulations that would address instances where issuers may inadvertently trigger a market withdrawal and 5-year ban on market reentry. For purposes of guaranteed renewability, a 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. Because of the continuity of the product, the ceding issuer would not be considered to have performed a market withdrawal when transferring all of its products within its controlled group. We also finalize that an issuer may replace all of its existing products with new products without triggering a market withdrawal, as long as the issuer matches new products with existing products for purposes of subjecting the new products to the Federal rate review requirements, as if the requirements applied to the new products, to the extent otherwise applicable to coverage of the same type and in the same market.

MLR Rebate Impact on New and Growing Issuers: We are finalizing amendments to the medical loss ratio (MLR) provisions that will allow issuers the option to defer reporting of policies newly issued with a full 12 months of experience (rather than only policies newly issued and with less than 12 months of experience) in that MLR reporting year, and the option to limit the total rebate liability payable with respect to a given calendar year.