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2018 Benefit and Payment Parameters Proposed Rule

OVERVIEW

On August 29th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule on benefit and payment parameters for plan years that begin on or after January 1, 2018. The rule proposes standards for issuers and Health Insurance Marketplaces created by the Affordable Care Act (ACA). Key provisions of the proposed rule include modifications to payment parameters, the risk adjustment program, standardized option plans, and other market reforms.

CMS will accept comments on the proposed rule until October 6th. This document summarizes several major provisions of the proposed rule, which is available here.

RISK ADJUSTMENT PROGRAM

The ACA's risk adjustment program is intended to mitigate the potential impact of adverse selection and stabilize the price of health insurance in the individual and small group markets. CMS proposes several updates to the risk adjustment methodology to accomplish these objectives.

Partial Year Enrollment

CMS proposes updates to better estimate the risk associated with enrollees who are not enrolled for a full 12 months. This update is based on feedback that the existing model underpredicts claims costs for enrollees who are enrolled for only part of a year. Partial year adjustment factors would be incorporated in the adult risk adjustment model for the adult 2017 and 2018 benefit year risk adjustment models.

CMS is not making this update in the child and infant models. CMS will reassess the models in the future as more data become available.

Prescription Drug Utilization

CMS proposes to use drug utilization data to improve the predictive accuracy of the risk adjustment models beginning in the 2018 benefit year. Drug indicators can predict health risk in cases where diagnoses may be missing, and drug utilization patterns can provide information on the severity of the illness. For benefit year 2018, CMS is proposing to incorporate a small number of prescription drugs in the risk adjustment model and evaluate the impact. Conditions that would be used for the updated risk adjustment include, but are not limited to: hepatitis C, HIV/AIDS, end-stage renal disease, diabetes, and inflammatory bowel disease.

High-Cost Risk Pool

CMS proposes to modify the treatment of high-cost enrollees in the risk adjustment model to improve the ability to predict risk for issuers who enroll sicker-than-average enrollees.

CMS proposes to create a pool of high-cost enrollees. Beginning in the 2018 benefit year, CMS proposes a threshold of $2 million and a coinsurance rate of 60 percent (the issuer would be liable for 40 percent of costs above $2 million).

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Issuers would fund the high-cost risk pool: risk-adjustment transfers would be modified based on the aggregate costs of the high-cost risk pool above $2 million at 60 percent coinsurance in the benefit year.

Two high-cost risk pools across all states would be created: one for the individual market and one for the small group market. CMS expects total adjustments as a result of this policy to be very small (less than one tenth of one percent of total premiums for either market).

CMS seeks comments on whether to cap the adjustments if a certain amount is exceeded.

Publication of Final Coefficients

CMS proposes to issue final 2018 benefit year coefficients prior to the 2018 benefit year risk adjustment calculations using the most recently available MarketScan data. CMS anticipates this would be published in the early spring of 2019. By adjusting this timeline, CMS would publish the final coefficients closer to the calculation of risk adjustment for the 2018 benefit year and provide risk adjustment coefficients that reflect the most current data available for the benefit year.

Future Recalibration

CMS proposes to use additional data and new processes from external data gathering environment (EDGE) servers to recalibrate the risk adjustment models beginning with the 2019 benefit year. Each issuer uses an EDGE server to submit data for the risk adjustment and reinsurance programs. CMS proposes to use masked enrollee-level data sets from the EDGE servers to recalibrate the risk adjustment models and inform the development of the Actuarial Value Calculator and risk adjustment methodology.

CMS also proposes to explore different regression methods to more accurately estimate costs for individuals designated at the high and low ends of the risk scale. To reduce underestimation of costs for low risk individuals, two methods are proposed to reduce the weight given to health condition status in the model, and increase the weight given to age, gender and/or sociodemographic variables. A direct modification of risk adjustment payments based on actual claims experience independent of the risk model is also under consideration. Comments on these options are requested.

PAYMENT PARAMETERS

Proposed modifications to payment parameters include, but are not limited to:

- **Federally-facilitated Exchange (FFE) User Fee:** CMS proposes to keep the 2018 FFE user fee rate of 3.5 percent for the fifth consecutive year;
- **State-based Marketplace on the Federal Platform (SBM-FP):** CMS proposes to charge issuers a user fee rate of 3 percent of premium for the 2018 benefit year;
- **Premium Adjustment Percentage and Maximum Cost Sharing:** CMS proposes a premium adjustment percentage increase of 2.6 percent from 2017, resulting in an increase of the 2018 maximum annual limitation on cost sharing to $7,350 for individual coverage and $14,700 cumulative for family coverage.

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STANDARDIZED PLAN OPTIONS

Prior to the 2017 Benefit and Payment Parameters Final rule, standardized metal levels determined equivalent actuarial values, but not equivalent cost-sharing structures. In the 2017 Payment Notice, CMS finalized its proposal to designate plans with certain cost-sharing structures as "standardized options." The rule created six standardized plan options, including a bronze plan, a standard silver plan, a gold plan, silver plans available for individuals eligible for cost-sharing reductions.

For 2018, CMS proposes to update the standardized plan options. CMS recognizes that some states were not able to offer standardized options due to state requirements on cost sharing. CMS proposes to expand the number of standardized options so that at least one standardized option in each level of coverage will comply with State requirements. CMS proposes four bronze standardized options, three standardized options at each of the silver levels, silver cost-sharing reduction variations, and gold levels. One of the bronze plans would be a health savings account-eligible high-deductible health plan option that would comply with the IRS Health Savings Account rules. Each State would only have one standardized option at each level of coverage.

MARKET REFORMS

Re-assessment of the Five-Year Ban on Market Reentry

CMS proposes changes to guaranteed renewability. CMS proposes to change the interpretation of what constitutes a "market withdrawal." In certain instances, the discontinuation of all coverage currently offered by an issuer in a market in a state would not be considered a market withdrawal subject to the five-year ban on market re-entry.

CMS also proposes that an issuer may replace all of its existing products with new products without triggering a market withdrawal, as long as the new products match the existing products for purposes of rate review.

Medical Loss Ratio (MLR) Rebate

Currently, issuers are allowed to defer reporting of policies newly issued and with fewer than 12 months of experience until the following reporting year, if such policies contribute to 50 percent or more of the issuer's total earned premium for the MLR reporting year.

CMS proposes to expand the MLR provision to allow issuers to defer reporting of policies newly issued with 12 full months of experience in that MLR reporting year, rather than policies with less than 12 months of experience.

Child Age Rating

CMS proposes to modify the child age rating structure. Effective for plan years beginning on or after January 1, 2018, CMS proposes one age band for individuals age 0 through 14, and then single-year age bands for individuals age 15 through 20.