spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

CMS Finalizes 2018 Marketplace Benefit and Payment Policies

OVERVIEW

On December 16th, the Centers for Medicare and Medicaid Services (CMS) published the Final Benefit and Payment Parameters for the 2018 plan year. The final rule implements several proposed changes to the marketplaces aimed to improve the risk pool for insurers by limiting special enrollment periods, strengthening the risk adjustment program, and implementing a reinsurance fund as part of risk adjustment. The rule also will standardize plan benefits on HealthCare.gov, revise child age rating bands, and revise federal rules to make it easier for an insurer who leaves the ACA market to re-enter in a future year.

The provisions of the final rule are effective on January 1, 2017. This document summarizes several major provisions of the final rule. The full final rule is available here.

RISK ADJUSTMENT CHANGES

- **Partial-year Enrollees and Prescription Drug Utilization.** CMS is changing its risk adjustment calculations to more accurately account for individuals who enroll mid-year through an SEP or who otherwise begin and end coverage without the issuer collecting a full-year's premium. This change will apply to both the 2017 and 2018 risk adjustment formulas. In addition, CMS will consider prescription drug events when calculating risk adjustment scores in the 2018 benefit year.

- **High-Cost Risk Fund.** CMS will change its risk adjustment transfer formula to compensate plans for 60% of costs for enrollee claims costs exceeding $1 million. Total adjustment transfers made due to this change are expected to be no more than 0.5% of total premiums.

- **Administrative Costs in Transfer Formula.** CMS is altering the risk adjustment transfer formula by reducing the calculated statewide average premium by 14%, which CMS expects to tie transfers to enrollee risk rather than plan administrative costs that do not vary with risk.

STRENGTHENING THE RISK POOL AND EASING INSURER BURDENS

- **Special Enrollment Periods (SEPs).** CMS is codifying certain SEPs that had previously been allowed under guidance related to "exceptional circumstances". In doing this, CMS is tightening the circumstances in which SEPs can be used, to limit inappropriate use or abuse of SEPs. The final rule formalized May 2016 changes, which limited access to the "permanent move" SEP by requiring that consumers to prove they had minimum essential coverage, for at least one day out of the 60-days prior to filing for that SEP.

- **Limits Renewals of Medicare-eligible Individuals.** Insurers with knowledge that a marketplace enrollee is eligible for Medicare will be prohibited from renewing him or her into an exchange or individual market policy or plan, effective with the date of the final rule.

- **Binder Payment Changes.** CMS will allow marketplaces, including the New York State of Health, to give issuers flexibility in collecting marketplace enrollees' initial (binder) payments when systems difficulties preclude collecting it within required time-frames.

- **Medical Loss Ratio (MLR) Rebate Changes for New and Growing Issuers.** CMS is allowing issuers with new products to limit their MLR liability and to defer MLR reporting for the first 12 months, effectively allowing the 3-year average used in MLR rebate determination to become a 4-year average. Products with low MLR and low enrollment in the first year but higher MLR and higher enrollment in subsequent years will find their average MLR used to assess rebate payments reduced. This is intended to reduce barriers to market entry.

- **Market Re-entry Changes.** CMS will allow issuers more flexibility to withdraw or revise its offerings in a state's market without triggering the federal 5-year ban on selling products in that state. Issuers may also withdraw all existing plans and replace them with new plans in the same market, without triggering a market withdrawal under federal law.

OTHER CHANGES

- **Standardized Plan Benefits on HealthCare.gov.** CMS is revising its standardized benefit options to allow insurers more leeway to comply with state requirements impacting insurance benefit design, while still qualifying as a HealthCare.gov standardized health plan.

- **Exchange Flexibility in Data Sources and Income Verifications.** The final rule allows exchanges more latitude than they previously had to examine data sources that could impact current enrollees' continued eligibility for exchange enrollment and/or financial assistance. Exchanges must also provide notice to enrollees who didn't file or reconcile their prior ACA tax credits as required by law, before those individuals' coverage can be terminated.

- **HealthCare.gov User Fees.** CMS will maintain the existing 3.5% user fee structure for issuers offering coverage on HealthCare.gov, except for issuers offering coverage on State Based Marketplaces on the HealthCare.gov Platform – Arkansas, Oregon, Kentucky, Nevada and New Mexico – where issuers will be charged 2% of premiums in 2018.

- **Child Age Band Ratings.** CMS is revising the child age rating to provide a more gradual transition across age bands as children get older. Specifically, the agency is establishing a single age band for individuals 0-14; followed by single-year age bands for each year for ages 15 - 20, effective in plan or policy years beginning January 1, 2018.

- **Annual Limitation on Cost Sharing.** CMS is increasing the annual limitation on cost sharing to $7,350 for individual coverage (up from $7,150 in 2017) and $14,700 (up from $14,300 in 2017), for family coverage in 2018. Stand-alone dental plans providing pediatric benefits, initially limited to $350 for a single child and $700 for more than one child, will be indexed to a formula based on the Consumer Price Index (CPI) for benefit years beginning in 2018.