On December 22, 2016 HHS published its Final Notice of Benefit and Payment Parameters for 2018\(^1\). The Notice contains rules and parameters that will apply to the individual and small group health insurance markets in 2018, and modifications to previously promulgated rules. This document represents a summary of our interpretation of the Notice but does not constitute, nor is it a substitute for, legal advice.

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HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

1. Requirements Relating to Health Insurance Coverage (§144.103)
   • The definition of Plan and Product as defined in §144.103 is modified such that a product can still be considered the same plan or product when it is offered by a different issuer in the same controlled group, even if it is no longer offered by the same issuer
   • HHS has clarified that a product that has been modified, transferred, or replaced would be considered to be the same product provided it meets the applicable standards for uniform modification from §146.152(f), §147.106(e), or §148.122(g)

2. Fair Health Insurance Premiums (§147.102)
   • The rating approach for individuals under age 21 will be changed, with an objective to better align rating factors with underlying costs, and mitigate the large observed rating increase from age 20 to 21
   • For policy years starting January 2018 or later, the current single rating factor for ages 0 to 21 is replaced by a single factor for ages 0 to 14, with increasing age rating factors for ages 15 to 20 using one-year age bands. Rating factors will increase significantly for all children (from the current 0.635 factor to a range of 0.765 to 0.970 depending on the age of the child)

3. Guaranteed Availability of Coverage (§147.104)
   • The Public Health Service Act allows network plans to limit the availability of coverage to employers in the small group or large group market to employees who live, work, or reside in the service area of such network plan
     − In this case, the employer is not required to be located in the service area of the network plan
   • Some issuers have network sharing agreements whereby an employer purchases coverage from the local network plan where the employer resides, but employees can access networks of affiliated issuers provided the employees reside in the service area of the affiliated network plans
     − As part of these arrangements, issuers typically agree to only offer coverage to employers that reside in their service area
     − HHS has taken the stance that this approach is non-compliant with guaranteed availability provisions, but has agreed to not take Federal enforcement actions against these plans for plan years starting prior to January 1, 2019, to allow for a restructuring of existing affiliation agreements

4. Guaranteed Renewability of Coverage (§144.106)
   • HHS has recognized some inconsistency in state interpretation of the events that would trigger five-year market bans where continuity of coverage is evaluated, within a different but related entity
     − HHS recognizes in §147.106(e)(3)(i) that, if continuity of coverage is effectively provided, for purposes of guaranteed renewability, a product would be considered to be 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
     − For the purposes of this provision the definition of controlled group is based on the IRS definition used to determine whether multiple groups are a single entity for the purposes of calculating the health insurance provider fee, unless a more narrow State definition applies
Products transferred across issuers are considered to be the same product and would not qualify as an issuance of “new” products; therefore, Federal rate review requirements are applicable to the rate increase on the transferred products

• In cases where a specific issuer completely replaces its current portfolio with a new set of products/plans not previously offered, it will no longer be considered a market exit triggering a five-year market ban provided the issuer identifies which new product replaces which prior product, and subjects these plans to the Federal rate review process
• HHS is allowing states with stricter interpretations to retain the ability to apply stricter criteria for determining a market withdrawal relative to the scenarios proposed above
• HHS will prohibit plans from knowingly renewing coverage for individuals eligible for Medicare benefits, unless the renewal is effectuated under the same policy or contract of insurance

5. Pre-Existing Condition Insurance Plan Program (§152.45)
• HHS has not finalized any guidance on if and how remaining funds provided for the Pre-Existing Condition Insurance Plan (PCIP) program under Section 1101 of the ACA might be used to ensure that former PCIP enrollees are able to transition successfully into the new Exchanges without a lapse in coverage

STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT

1. Sequestration
• Without further Congressional action, payments made from the transitional reinsurance and risk adjustment programs using fiscal year 2017 resources will be sequestered at a rate of 6.9% and 7.1%, respectively
  - The sequestered funds will become available for payment in fiscal year 2018

2. Definition of Large Employer for the Risk Adjustment and Risk Corridor Programs (§153.20)
• HHS clarified for risk adjustment and risk corridor purposes, issuers should use the employee counting method used to determine group size under state law, provided such methodology accounts for part-time employees; if not, the issuer should use the counting method prescribed under the ACA
• HHS clarified when a small employer group purchases coverage through the Small Business Health Options Program (SHOP) and ceases to be classified as a small group because of an increase in the number of employees, the employer group should be treated as a small employer group for purposes of SHOP participation, risk adjustment program and risk corridor program as long as the employer group purchases coverage through the SHOP

• Starting with the 2017 benefit year for states in which HHS operates risk adjustment, HHS will expand its interpretation of merged markets, at the state’s discretion, to include states that require issuers to use combined individual and small group market experience to develop a market-adjusted index rate for each market
• HHS will incorporate the following elements into the risk adjustment program:
  - Partial year enrollment duration factors for adults will be incorporated into the 2017 benefit year risk adjustment model
The factors vary by metal level and decrease monotonically as duration increases (e.g., the factor for Silver plans will range from 0.396 for one month to 0.084 for 11 months in 2017).

A different set of partial year factors will be used in the 2018 model.

Child and infant models will not be impacted by the change since these models are based on smaller datasets that do not provide adequate representation of partial year enrollment.

Preventive services will be incorporated in estimating plan liability for 2017.

HHS will adopt a more granular approach to trends, reflecting, for example, high growth in the cost of specialty drugs.

Prescription drug utilization indicators will be incorporated into the 2018 benefit year risk adjustment model for adults.

Prescription Drug Categories (RXCs) were developed from the United States Pharmacopeia (USP) classifications, with each RXC closely associated with a specific HCC or a group of HCCs.

Two types of RXCs will be incorporated into the model:

- Imputation/severity: presence of a drug implies that an individual has a related diagnosis.
- Severity-only: presence of a drug indicates an individual has a more severe case of the related diagnosis, but presence of the RXC does not increase the risk score in the absence of the HCC.

CMS will closely monitor the prescription drug utilization associated with the RXCs included in the risk adjustment process for unintended utilization.

HHS will release a list of the specific drugs included in the 2018 benefit year risk adjustment model in a manner similar to the release of revisions to the accepted diagnosis and service codes for risk adjustment.

A high-cost risk pooling mechanism will be incorporated into the calculation of the 2018 benefit year risk adjustment transfers.

For members with claim costs exceeding $1 million, issuers will be reimbursed 60% of claim costs above $1 million.

Claims data submitted through the EDGE server will be used to determine the pooled claim amounts.

There will be two risk pools across all states: one for the individual market and one for the small group market.

To fund the high-cost risk pooling mechanism, issuers will be assessed a uniform percentage of total premiums in the respective market (expected to be less than 0.5% of premiums for either market).

Assessment will be applied to the total transfer amount within a given market and will maintain the balance of payments/charges under the risk adjustment program.

If an issuer fails the data quality analysis for a risk adjustment transfer and therefore was charged the default risk adjustment assessment, additional data quality metrics will be applied to determine an issuer’s eligibility for the high-cost risk pooling adjustment.

- HHS is amending §153.320(a)(1) to state that a risk adjustment methodology may be developed by HHS and published in rulemaking in advance of the benefit year, instead of being published in the annual HHS Notice of Benefit and Payment Parameters for the applicable benefit year.
- HHS intends to make changes to the risk adjustment methodology in the applicable annual HHS Notice of Benefit and Payment Parameters, but this amendment will give HHS the flexibility to implement changes prior to the applicable benefit year, if necessary.

The 2018 benefit year risk adjustment model will separate the Chronic Hepatitis HCC into the following HCCs for the adult, child and infant models:

- Hepatitis C
- Hepatitis A and B
• The risk transfer calculation will be updated for the 2018 benefit year to account for the high-cost risk pooling mechanism, and an additional adjustment will be applied to the calculation of the statewide average premium to remove the impact of administrative expenses from premiums
  – The statewide average premium will be multiplied by a factor of 0.86, reducing the magnitude of risk transfer receipts/payments
• HHS will release the final risk adjustment coefficients for the 2018 benefit year in the spring of 2017 using a blend of 2013, 2014 and 2015 MarketScan data
  – The current cost-sharing reduction adjustment factors will remain in place for the 2018 benefit year risk adjustment model
• HHS intends to base the 2019 risk adjustment model and the 2019 AV Calculator on the 2016 data collected through the EDGE server
  – HHS is also considering releasing a public use file based on data submitted through the EDGE server
• The risk adjustment user fee will increase from $1.56 per member per year to $1.68 per billable member per year, pro-rated on a monthly basis
  – HHS will assess the risk adjustment user fee based on the billable member months instead of member months, starting with collection of the 2016 benefit year risk adjustment user fee in 2017
• HHS will implement a materiality threshold starting with the 2017 benefit year risk adjustment data validation process
  – Issuers with total premiums subject to risk adjustment of less than $15 million in a given benefit year (representing roughly 1.5% of membership nationally) will not be required to conduct risk adjustment data validation for the given benefit year but will be subject to random, targeted sampling
  – The error rate for an issuer not subject to an initial validation audit will be the lower of the national average negative error rate and the average negative error rate within the given state
• §153.630(b)(7)(ii) has been amended to include paid prescription drug claims as part of the initial validation audit entity
• HHS is amending §153.630(d) to clarify that an issuer may appeal the results from the second validation audit or the calculation of the risk score error rate
  – HHS distinguishes the calculation of a risk score error rate from the application of a risk score error rate, since the calculation is separate from the application, and an appeal related to the application of a risk score error rate must be done under §156.1220(a)(1)(ii)

EXCHANGE ESTABLISHMENT STANDARDS

1. Standardized Options (§155.20)
• HHS is revising the standardized benefit options to be offered in the individual market, now referred to as “Simple Choice” plans
  – 2018 standard benefit options reflect changes in the most popular qualified health plans (QHPs) from 2015 to 2016 in Federally Facilitated Exchanges (FFEs), and State-Based Exchanges using the Federal Platform (SBE-FPs)
  – There are three sets of standardized options with the second and third sets intended to satisfy various state-specific cost sharing requirements; only one set will be selected for a given FFE state based on that state’s cost sharing requirements
  – Unlike the 2017 versions, the Silver, Silver cost sharing reduction (CSR) variants, and Gold levels have separate medical and drug deductibles
• There will be two standardized plan options at the Bronze level, one of which qualifies as a high deductible health plan (HDHP), eligible for use with a Health Savings Account (HSA)
  - 9.2% of 2016 enrollment in FFEs and SBE-FPs was in HDHPs
  - Since the cost sharing limits that apply to HDHPs are published after the annual HHS Notice of Benefit and Payment Parameters, the standardized Bronze HDHP plan will be revised in guidance if needed to comply with the final HDHP requirements for 2018

• Standardized options in FFE states will continue to receive differential display; such display may change based on additional consumer testing and experiences with the 2017 differential display

• Offering of the standardized plans remains optional

• Consistent with 2017, issuers may offer a single additional lower cost generic drug tier other than drugs that are considered preventive in nature (and covered with no member cost-sharing)

• Healthcare.gov remains unable to allow differential display of state-designed standardized plans; however, SBE-FPs may choose to allow the HHS-designed standardized plans to receive differential display

Exhibit 1: Key features of the first set of 2018 standard plans

<table>
<thead>
<tr>
<th>BENEFIT PROVISION</th>
<th>BRONZE</th>
<th>BRONZE HDHP</th>
<th>SILVER</th>
<th>SILVER (73% AV)</th>
<th>SILVER (87% AV)</th>
<th>SILVER (94% AV)</th>
<th>GOLD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial value</td>
<td>62.68</td>
<td>61.97</td>
<td>71.05</td>
<td>73.95</td>
<td>87.61</td>
<td>94.69</td>
<td>80.65</td>
</tr>
<tr>
<td>Deductible (Med/Rx)</td>
<td>$6,650</td>
<td>$6,000</td>
<td>$3,500/$500</td>
<td>$3,000/$200</td>
<td>$700/$0</td>
<td>$250/$0</td>
<td>$1,400/$0</td>
</tr>
<tr>
<td>Annual OOP</td>
<td>$7,350</td>
<td>$6,000</td>
<td>$7,350</td>
<td>$5,850</td>
<td>$2,450</td>
<td>$1,250</td>
<td>$5,000</td>
</tr>
<tr>
<td>PCP office visits</td>
<td>$351</td>
<td>0%</td>
<td>$301</td>
<td>$301</td>
<td>$101</td>
<td>$51</td>
<td>$201</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$751</td>
<td>0%</td>
<td>$651</td>
<td>$651</td>
<td>$251</td>
<td>$101</td>
<td>$501</td>
</tr>
<tr>
<td>PT/OT/ST</td>
<td>40%</td>
<td>0%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>5%</td>
<td>20%</td>
</tr>
<tr>
<td>Emergency room</td>
<td>40%</td>
<td>0%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>5%</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>40%</td>
<td>0%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>5%</td>
<td>20%</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$351</td>
<td>0%</td>
<td>$151</td>
<td>$151</td>
<td>$51</td>
<td>$31</td>
<td>$101</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>35%</td>
<td>0%</td>
<td>$501</td>
<td>$501</td>
<td>$251</td>
<td>$51</td>
<td>$401</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>45%</td>
<td>0%</td>
<td>40%</td>
<td>40%</td>
<td>30%</td>
<td>25%</td>
<td>30%</td>
</tr>
</tbody>
</table>

1 Not subject to deductible

• The second set of standardized plans is intended for states requiring occupational therapy, physical therapy, or speech therapy (PT/OT/ST) cost-sharing parity with primary care visits, or states requiring copayments or copayment limits on prescription drugs
  - All drug tiers are subject to a copayment, some only after the deductible has been satisfied
  - These plans will be used in Arkansas, Delaware, Iowa, Kentucky (if the SBE-FP opts in), Louisiana, Missouri, Montana, and New Hampshire

• The third set of plans are intended for states with deductible maximums or other cost-sharing requirements
  - The maximum deductible on this set of plans is $3,000
  - There is no specialty drug tier on these plans
  - These plans will be used in New Jersey

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2. General Functions of an Exchange

Functions of an Exchange (§155.200)

• SBE-FP states are required to establish standards and policies consistent with the Federally Facility SHOP (FF-SHOP) requirements, due to their being an integral part of the platform’s functionality and system build, in the following areas:
  − Premium calculation, payment and collection
  − Timeline for rate changes
  − Minimum participation rate requirements and calculation methodologies
  − Employer contribution methodologies
  − Annual employee open enrollment period
  − Initial group enrollment or renewal coverage effective date
  − Termination of SHOP coverage or enrollment

Consumer Assistance Tools and Programs of an Exchange (§155.205)

• For purposes of taglines (for limited English proficient (LEP) populations, taglines indicate the availability of non-English language services) on website content and documents that are critical for obtaining health insurance coverage or access to health care services through a QHP:
  − If an Exchange operates in multiple states, the Exchange may aggregate the LEP populations across the states in which it operates to determine the top 15 languages
  − Issuers that operate in multiple states may aggregate the top 15 languages in the states in which they operate, including subsidiary issuers as long as the subsidiary issuers will be treated as a single employer and not, for example, an association of issuers
  − Taglines must still be provided for languages when 10% or more of the population residing in a county is literate only in that language without aggregating populations
  − Taglines may be provided in additional languages, if desired
  − A prominent web link that directs individuals to the full text of the taglines is sufficient, provided the taglines are also included in any critical standalone documents

• For purposes of summaries of benefits and coverage, the top 15 languages need to be applicable to the relevant state in which the coverage is written

Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§155.220)

• Web-brokers and issuers that use the direct enrollment pathway are required to differentially display standardized options when they facilitate enrollment through an FFE or an SBE-FP that elects to implement differential display
  − The manner of differentiation is not required to be identical to the one used on Healthcare.gov, provided approval for any deviations is obtained from HHS
  − Approval for deviations will consider whether the same level of differentiation and clarity is being provided

• HHS is maintaining the current “double redirect” direct enrollment approach rather than implementing an enhanced direct enrollment process whereby a consumer might remain on the direct enrollment partner’s website to submit information necessary for an eligibility determination
Additional Protections for the Current Direct Enrollment Process and FFE Standard of Conduct for Agents and Brokers (§155.220)

- The following modifications are made for agents and brokers that use the direct enrollment process to ensure adequate consumer protections:
  - Web-brokers are required to display information pertaining to eligibility for advanced premium tax credits (APTCs) and CSRs in a prominent manner
  - The Exchange is required to receive certain attestations from the tax filer, and permit an enrollee to accept less than the full amount of APTC for which the enrollee is eligible; accordingly, web-brokers are required to allow consumers to select an APTC amount and make related attestations
  - Web-brokers are required to demonstrate operational readiness, including compliance with applicable privacy and security requirements, prior to accessing the direct enrollment pathway
  - HHS is allowed to immediately suspend an agent or broker’s ability to transact information with the Exchange as part of the direct enrollment pathway if HHS discovers circumstances that pose unacceptable risk to Exchange operations or its information systems
  - Web-brokers that provide access to their direct enrollment pathway to other third-party agents and brokers are responsible for ensuring those websites are compliant with this section of regulation; the third-party may be required to enter into an agreement with HHS to ensure compliance with requirements that ensure security of HHS systems
- Agents and brokers that assist with enrollment through an FFE or SBE-FP are not allowed to maintain a website that could mislead consumers into believing they are visiting Healthcare.gov; for example, a website would not be allowed to use colors, text sizes, or fonts that are similar in totality to those used by Healthcare.gov

Standards for HHS-Approved Vendors to Perform Audits of Agents and Brokers Participating in Direct Enrollment (§155.221)

- This new section establishes an application and approval process for evaluating and approving third party audit vendors of Web-broker compliance with direct enrollment requirements
  - Vendors will be approved by HHS annually for one-year terms
  - HHS may audit vendors to ensure ongoing compliance with HHS standards
  - Approved entities will be published on an HHS website

General Standards for Exchange Notices (§155.230)

- Electronic notices will be the default method for sending SHOP Exchange notices unless otherwise required by Federal or State law
  - Mailed notices will be optional at the election of the employer or employee, unless Federal or State law prohibits making paper notices optional
  - Employers and employees participating in FF-SHOPs or in SBE-FPs for SHOP functions will continue to be able to select their preferred communication method when completing the eligibility applications online at Healthcare.gov
- If an individual market Exchange or SHOP is unable to send notices electronically, HHS will give the Exchange or SHOP the flexibility to send notices through standard mail instead
3. Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

Eligibility Determination (§155.305)

- The Exchanges should not determine a consumer eligible for an APTC if APTC payments were made on behalf of the tax filer for the consumer’s household (or either spouse, if the tax filer is a married couple) for a previous year and the tax filer or his or her spouse did not comply with the requirement to file an income tax return and reconcile any APTCs received for a previous year.
  - Eligibility for an APTC may not be denied unless a direct notification is first sent to the tax filer that his or her eligibility will be discontinued as a result of the tax filer’s failure to comply with the requirement to file an income tax return and reconcile an APTC received for a previous year.

Eligibility Redetermination during a Benefit Year (§155.330)

- The Exchange is required to periodically examine available data sources for eligibility determinations for, or enrollment in, certain government health programs.
  - Exchanges need to consider which data sources best meet the criteria of timeliness, accuracy, and availability.
- HHS will require the Exchange to choose among three alternatives when the Exchange identifies updated information regarding compliance with the income tax filing and reconciliation requirement under §155.305(f)(4):
  - Follow the procedures specified in paragraph (e)(2)(i).
  - Follow alternative procedures specified by the Secretary in future guidance.
  - Follow an alternative process proposed by the Exchange and approved by the Secretary based on demonstrating the process meets the following necessary approval criteria:
    - Facilitates continued enrollment in coverage with financial assistance for which the enrollee remains eligible.
    - Provides appropriate information about the process to the enrollee.
    - Provides adequate program integrity protections and safeguards for Federal tax information.
- HHS will allow the Exchange to recalculate APTC amounts in accordance with an eligibility redetermination under §155.330 using an alternate method approved by the Secretary.
  - The alternate procedure would be required to provide adequate program integrity protections, minimize administrative burden on the Exchange, and limit negative impacts on consumers, where possible.

4. Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

Enrollment of Qualified Individuals into QHPs (§155.400)

- HHS will give the Exchange the discretion to allow issuers experiencing billing or enrollment problems due to high volume or technical errors to implement a reasonable extension of the binder payment deadlines.
  - This extension is not expected to be more than 45 calendar days in duration and must be implemented in a uniform and nondiscriminatory manner.
- All binder payments rule will apply to SBE-FPs in addition to FFEs.

Special Enrollment Periods (§155.420)

- The following special enrollment periods that were made available through prior guidance are now codified:
  - Dependents of Indians on the same application as the Indian at §155.420(d)(8)(ii).
  - Victims of domestic abuse or spousal abandonment at §155.420(d)(10).
- Medicaid or CHIP denials at §155.420(d)(11)
- Material plan or benefit display errors at §155.420(d)(12)
  - In order to qualify for this special enrollment period, consumers must demonstrate to the Exchange that this error impacted his or her decision to purchase a QHP
- Data matching issues that are cleared post-expiration of an inconsistency period or individuals who are verified through the data matching process to meet the citizenship, national, or immigration criteria described in section 1401(c)(1)(A)(ii) of the Affordable Care Act at §155.420(d)(13)

• The Exchange has the flexibility to provide a consumer with a later coverage effective date, at the consumer’s option, if his or her ability to enroll in coverage is delayed so that he or she would owe two or more months of premiums retroactively if his or her coverage effective date were set based on their plan selection date under existing coverage effective date rules

**Termination of Exchange Enrollment or Coverage (§155.430)**

- HHS will require an issuer that seeks to rescind coverage in a QHP purchased through an Exchange to first demonstrate, to the reasonable satisfaction of the Exchange, that the rescission is appropriate


- HHS will permit the Exchange appeals entity to utilize paper-based appeals processes for the acceptance of appeal requests, the provision of appeals notices, and the secure transmission of appeals-related information between entities, when the Exchange appeals entity is unable to establish and perform otherwise required, related electronic functions

6. **Exchange Functions in the Individual Market: Required Contribution Percentage (§155.605(e)(3))**

- HHS is setting the 2018 required contribution percentage (the affordability exemption) to be 8.05% of household income
  - The required contribution percentage was 8.00% for 2014, 8.05% for 2015, 8.13% for 2016 and 8.16% for 2017

7. **Exchange Functions: Enrollment Periods under SHOP (§155.725)**

- HHS will require SHOPs to provide an employee who becomes a qualified employee outside of the initial or annual open enrollment period with a 30-day enrollment period that would begin on the date the qualified employer notifies the SHOP about the newly qualified employee
  - Qualified employers are required to notify the SHOP about a newly qualified employee on or before the 30th day after the day that the employee becomes eligible for coverage
  - As a result of this modification, HHS is removing the requirement that enrollment periods for newly qualified employees must end no sooner than 15 days prior to the date that any applicable employee waiting period longer than 45 days would end, if the employee made a plan selection on the first day of becoming eligible
  - The coverage effective date for a newly qualified employee is the first day of the month following the plan selection unless the employee would be subject to a waiting period consistent with §147.116 and proposed paragraph (g)(3), in which case the effective date is the first day of the month following the end of the waiting period
  - If a newly qualified employee’s waiting period ends on the first day of a month and the employee has already made a plan selection by that date, coverage will also be effective on that date
If a newly qualified employee makes a plan selection on the first day of a month and any applicable waiting period has ended by that date, coverage will be effective on the first day of the following month.

- If a qualified employer with variable hour employees makes regularly having a specified number of hours of service per period (or working full-time) a condition of employee eligibility for coverage offered through a SHOP, any measurement period that the qualified employer uses to determine eligibility must not exceed 10 months.

- HHS will require that as long as the employee subject to a waiting period would be able to make a plan selection that results in coverage becoming effective within the required timeframes, coverage that begins later as a result of the employee’s delay in making a plan selection does not constitute a failure to comply with the waiting period limitations.

- Waiting periods in a SHOP may not exceed 60 days in length.
  - Waiting periods in a SHOP will be calculated beginning on the date the employee becomes eligible regardless of when the qualified employer notifies the SHOP about the newly qualified employee.

- A FF-SHOP or a State-based SHOP that uses the Federal platform for SHOP eligibility or enrollment functions may only allow waiting periods of 0, 15, 30, 45, or 60 days.

8. Exchange Functions: SHOP Employer and Employee Eligibility Appeals Requirements (§155.740)

- SHOP employer and employee eligibility appeals processes are allowed to use a secure and expedient paper-based process if the appeals entity cannot fulfill certain electronic requirements.


- An issuer that has applied to an FFE for certification of QHPs and has been denied certification is required to submit to HHS a written request for reconsideration within seven calendar days of the date of written notice of denial of certification.

HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

1. FFE User Fee for the 2018 Benefit Year (§156.150)

- The user fee rate for issuers offering coverage through the FFE in 2018 will be 3.5% of premium, unchanged from the 2014–2017 fee.
  - HHS does not believe this fee will fully cover the cost of operating the FFE, and they have sought an exception from the requirement that the user fee be sufficient to recover the full cost to the Federal government.
  - This user fee will be maintained for future benefit years, until changed through future rulemaking.

- The user fee rate for issuers offering coverage through the SBE-FP in 2018 will be 2.0% of premium.
  - While a 3.0% fee represents HHS’s actual cost, HHS phased the fee in and charged 1.5% of premium in 2017 and will further phase the fee in for 2018.

2. Single Risk Pool (§156.80)

- The plan adjusted index rate must be calibrated to reflect an age rating factor of 1.0, a geographic factor of 1.0 and a tobacco factor of 1.0.
  - The same calibration factors must be applied to all plans.
- Additional detail regarding the calibration will be provided in the forthcoming instructions to the Unified Rate Review Template

3. Essential Health Benefits Package

Premium Adjustment Percentage (§156.130)

- The maximum annual limitation for cost sharing, the required contribution percentage for minimum essential coverage (MEC), and the large employer penalty are adjusted annually by the percentage by which average per capita premium for health insurance for the prior year exceeds the average per capita premium for health insurance for 2013
- The 2018 adjustment percentage was calculated to be 16.2%, based on the projected increase of 2017 premium over 2013 premium by the National Health Expenditure Accounts (NHEA) for employer-sponsored coverage
- Results are rounded to the next lowest multiple of $50; family provisions are twice the single levels
- Maximum out-of-pocket (MOOP) limits for 2018 will be $7,350 for self-only and $14,700 for other than self-only coverage

Reduced Maximum Annual Limitation on Cost Sharing (§156.130)

Exhibit 2: MOOP limits for CSR plans for self-only coverage for 2018

<table>
<thead>
<tr>
<th>FPL</th>
<th>AV</th>
<th>REDUCTION IN MOOP</th>
<th>2018 MOOP SELF-ONLY</th>
<th>2018 MOOP OTHER THAN SELF-ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>100–150%</td>
<td>0.94</td>
<td>2/3</td>
<td>$2,450</td>
<td>$4,900</td>
</tr>
<tr>
<td>150–200%</td>
<td>0.87</td>
<td>2/3</td>
<td>$2,450</td>
<td>$4,900</td>
</tr>
<tr>
<td>200–250%</td>
<td>0.73</td>
<td>1/5</td>
<td>$5,850</td>
<td>$11,700</td>
</tr>
</tbody>
</table>

Levels of Coverage: Bronze Plans (§156.140)

- To ensure going forward that Bronze plans will be able to be developed which are at least as generous as the Catastrophic plan, HHS is revising the de minimis range to -2% to +5% for qualified HDHP plans, and Bronze plans that offer coverage for at least one major service, in addition to preventive services, prior to the deductible being met
- The additional services not subject to the deductible are required to be similar in scope and magnitude to the three primary care visits covered below the deductible for the Catastrophic plan, with “major service categories” defined as the following: primary care visits; specialist visits; inpatient hospital services; generic, specialty or preferred brand drugs; or emergency room services
- Reasonable cost sharing requirements must apply to the “major service category” to ensure the service is affordably covered
  - Any cost-sharing rate that requires the enrollee to pay for more than 50% coinsurance (or equivalent copay rate) for a major service category could be considered unreasonable
- Mental health and substance use disorder parity requirements still apply, and HHS notes that the AV Calculator is not intended for testing compliance with mental health and substance use disorder parity requirements given the standard population underlying the AV Calculator is not the same as the population that is required to be used for mental health and substance use parity testing
- The Final 2018 AV Calculator allows the wider de minimis range for Bronze plans, but does not assess whether plans that offer coverage prior to the deductible being met comply with the requirement to cover one major service category

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Application to Stand-alone Dental Plans Inside the Exchange (§156.150)

- Using the methodology for updating the annual limitation on cost sharing for stand-alone dental plans (SADPs) as outlined in the 2017 Benefit and Payment Parameter Notice, the annual limitation on cost sharing for 2018 will remain at $350 for one covered child and $700 for two or more children.

4. Qualified Health Plan Minimum Certification Standards

QHP Issuer Participation Standards (§156.200)

- HHS clarified that the requirement for QHPs to offer at least one Silver and one Gold plan through the Exchanges applies across the entire service area for each service area that the issuer offers coverage through an Exchange.
  - This requirement can be met by offering a multi-State plan at each coverage level.
- Effective for plan years beginning January 1, 2018, HHS is eliminating the requirement that issuers who participate in the individual Exchange and also have at least a 20% share of the small group market must participate in the FF-SHOP, due to the concern some issuers may not be participating in the individual Exchange because of this requirement.

Network Adequacy Standards (§156.230)

- HHS will incorporate more specificity into the network breadth indicators for QHPs, in particular identifying whether a plan is offered as part of an integrated delivery system (IDS).
  - Plans will be identified as part of an IDS based on whether a majority of professional services are provided through employed physicians or a single contracted medical group.
- HHS reminds issuers that provisions finalized in the 2017 Benefit and Payment Parameter Notice related to a requirement that cost sharing applied to EHBs charged by an out-of-network provider at an in-network facility must be counted toward in-network out-of-pocket limits if prescribed notification requirements are not met will be effective in 2018.
  - This policy will apply to QHPs sold both on and off the Exchanges, regardless of whether the plan covers out-of-network services.

Essential Community Provider Standards (§156.235)

- HHS will continue the 2017 counting methodology, such that multiple providers at a single location will continue to be counted as a single ECP toward both the available ECPs in the plan’s service area and the issuer satisfaction of the ECP participation standard.

Issuer Participation for the Full Plan Year (§156.272)

- QHP issuers in all individual and SHOP Exchanges will be required to make their QHPs available for enrollment through the Exchange for the entire plan year, unless a basis for suppression under §156.815 applies.
  - Issuers that do not comply could be subject to a civil money penalty (CMP) and suspended from participating in the Exchange for up to two years.

Non-Certification and Decertification of QHPs (§156.290)

- HHS will require that when issuers are denied certification for a subsequent, consecutive certification cycle they must notify enrollees within 30 days of receiving such notification using the notification following the same form and manner as the notices required under §147.106.

Other Considerations

- HHS confirmed that a plan is permitted to offer a participatory wellness program (i.e., one that does not condition a reward on an individual satisfying a standard related to a health factor or that does not provide a reward) in the individual market, provided that such a program complies with applicable state law and is available to all similarly situated individuals enrolled in individual health insurance coverage.

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5. Eligibility and Enrollment Standards for Qualified Health Plan Issuers on State-Based Exchanges on the Federal Platform (§156.350)

- HHS will require QHP issuers offering coverage through SBE-FPs which use the Federal platform for SHOP enrollment functions to follow the same requirements related to eligibility and enrollment that are applicable to QHP issuers offering coverage through the FF-SHOP
  - SBE-FPs will need to provide plan data to HHS by dates specified in the annual Letter to Issuers

6. Reconciliation of the Cost-Sharing Reduction Portion of Advance Payments Discrepancies and Appeals (§156.430(h))

- Issuers that dispute the amount of the reconciliation of the cost-sharing reduction portion of advance payments will be required to report the discrepancy within 30 calendar days of notification of the reconciliation amount
  - Issuers will be able to appeal the amount of the reconciliation only if they have submitted a discrepancy report
  - A request for reconsideration must be filed within 60 days of the date of the cost-sharing reduction reconciliation discrepancy resolution decision
- Issuers will only be able to contest processing errors by HHS, HHS’s incorrect application of the relevant methodology, or mathematical errors by HHS

7. Compliance Reviews of QHP Issuers in Federally-Facilitated Exchanges (§156.715)

- HHS amended this section to specify its authority to impose remedies against QHP issuers who are non-responsive or uncooperative with compliance reviews

8. Qualified Health Plan Issuer Responsibilities

Administrative Appeals (§156.1220)

- Appeals related to a second validation risk adjustment audit or calculation of a risk score error rate may only be filed for processing errors by HHS, HHS’s incorrect application of the relevant methodology, or mathematical errors by HHS
  - A reconsideration may be filed only if, to the extent the issue could have been previously identified, a report for discrepancies was filed with no resolution achieved prior to filing a request for reconsideration
  - These rules will first apply for the 2016 benefit year
- Issuers are required to file a reconsideration request within 30 calendar days of notification related to findings of a second validation audit and calculation of a risk score error rate

Direct Enrollment with the QHP Issuer in a Manner Considered to be Through the Exchange (§156.1230)

- QHP Issuers using direct enrollment will be subject to the following requirements:
  - HHS may suspend the QHP issuer’s ability to transact information with the Exchange if it would pose unacceptable risk to Exchange operations or IT systems
  - QHP issuers are required to demonstrate operational readiness and compliance prior to their websites being used to complete QHP selections
  - QHP issuers are required to provide consumers with correct information regarding FFEs, QHPs, and affordability programs, and refrain from misleading, coercive, or discriminatory marketing or conduct

Other Notices (§156.1256)

- HHS is codifying the special enrollment period that is made available to individuals after notification by QHP issuers of an error in the display of plan or benefit information on the FFE or SBE-FP
1. Newer Experience (§158.121)
   • Issuers will be allowed to defer, for MLR purposes, reporting of experience for policies newly issued in a given year if 50% or more of the issuer’s total earned premium for the MLR reporting year is attributable to policies newly issued in that year, including newly issued policies with 12 full months of experience
     − Any deferred experience will be required to be reported in the next MLR reporting year
     − Additional details will be provided when the MLR Annual Reporting Form Instructions are updated for future reporting years

2. Rebating Premium if the Applicable Medical Loss Ratio Standard is Not Met (§158.232, §158.240)
   • In order to reduce barriers to entry and growth, issuers in appropriate cases may limit their total rebate liability payable in a given calendar to no more than the amount determined based on the issuer’s MLR calculated using only that year’s experience
     − The maximum rebate liability attributable to a given calendar year in each of the two subsequent reporting years will be required to reflect:
       − A restatement of claims incurred in that calendar year as of March 31 following each of those two subsequent reporting years
       − A recalculation of the liability based on credibility applicable in each of those two subsequent reporting years
     − The recalculated maximum liability for each calendar year in the reporting period will be reduced by any rebate payments made toward that year in the two prior years, to determine the outstanding rebate liability for that year
     − The actual rebate payable for a given reporting year will be the lesser of the outstanding rebate liability for all years combined (two or three years, as applicable), and the liability under the multi-year averaging rule
   • HHS will publish on its website an updated MLR Calculator and Formula Tool in the near future that will enable users to evaluate the impact of this provision and illustrate the application of rebate payments made in prior years against the maximum rebate liability of each year
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Special thanks to: Kurt Giesa, Jac Joubert, Peter Scharl, Ryan Schultz, and Dianna Welch for their contribution to this paper.

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