ACA COMPLIANCE BULLETIN

HIGHLIGHTS

- The ACA's out-of-pocket maximum limit increases to $7,350 (self-only coverage) and $14,700 (family coverage).
- The required contribution percentage for the individual mandate's affordability exemption is decreased for 2018.
- Three new sets of standardized plan options are established in the individual market federal Exchanges.

IMPORTANT DATES

January 17, 2017
The 2018 Notice of Benefit and Payment Parameters is effective Jan. 17, 2017.

2018 Benefit Year
The changes included in the final rule generally apply for the 2018 benefit year.

Provided By:
New England Employee Benefits Co.

Final 2018 Notice of Benefit and Payment Parameters

OVERVIEW

On Dec. 16, 2016, the Department of Health and Human Services (HHS) released its **final Notice of Benefit and Payment Parameters for 2018**. This rule describes benefit and payment parameters under the Affordable Care Act (ACA), applicable for the 2018 benefit year. Updated standards included in the rule relate to:

- Annual limitations on cost-sharing;
- The individual mandate's affordability exemption; and
- Special enrollment periods in the Exchange.

The final rule also enhances standards for state-based Exchanges on the federal platform (SBE-FPs) and creates three new sets of six standardized benefit plan options in the federally facilitated Exchange (FFE).

Finally, the rule provides additional clarity on the special enrollment periods available through the FFE, and updates the ACA's current child age rating structure to provide a more gradual transition when individuals move from age 20 to 21.

NEEBCo
New England Employee Benefits Company
15 Chenell Drive, Concord, New Hampshire 03301
603.228.1133 Fax 603.225.1960 www.neebco.com

Annual Limitations on Cost-sharing

Effective for plan years beginning on or after Jan. 1, 2014, the ACA requires non-grandfathered plans to comply with an overall annual limit—or an out-of-pocket maximum—on essential health benefits (EHB). The ACA requires the out-of-pocket maximum to be updated annually based on the percent increase in average premiums per person for health insurance coverage.

- For 2016, the out-of-pocket maximum is **$6,850 for self-only coverage** and **$13,700 for family coverage**.
- For 2017, the out-of-pocket maximum is **$7,150 for self-only coverage** and **$14,300 for family coverage**.
- Under the final rule, the out-of-pocket maximum increases for 2018 to **$7,350 for self-only coverage** and **$14,700 for family coverage**.

Under the final rule, the required contribution percentage used to determine eligibility for an exemption from the individual mandate decreases to 8.05 percent in 2018.

Individual Mandate's Affordability Exemption

Under the ACA, individuals who lack access to affordable minimum essential coverage (MEC) are exempt from the individual mandate penalty. For purposes of this exemption, coverage is considered affordable for an employee if the required contribution for the lowest-cost, self-only coverage does not exceed **8 percent of household income**.

This required contribution percentage is adjusted annually after 2014, as follows:

- For 2015, the required contribution percentage is **8.05 percent of household income**.
- For 2016, the required contribution percentage is **8.13 percent of household income**.
- For 2017, the required contribution percentage is **8.16 percent of household income**

Under the final rule, the required contribution percentage **decreases in 2018**. The final rule provides that, for 2018, an individual is exempt from the individual mandate penalty if he or she must pay more than **8.05 percent of his or her household income** for MEC.

Exchange Special Enrollment Periods

Under the Exchanges, certain special enrollment periods (SEPs) are available to ensure that people who lose health insurance during the year, or who experience other qualifying events, have the opportunity to enroll in coverage. In 2016, HHS added warnings on www.healthcare.gov about inappropriate use of SEPs, eliminated SEPs that are no longer needed and enhanced eligibility rules. HHS also introduced a Special Enrollment Confirmation Process under which consumers enrolling through the most common SEPs are directed to provide documentation to confirm their eligibility for their SEP.

The final rule acknowledges that this new eligibility verification process may delay enrollment for some individuals. In response to these concerns, the final rule provides an Exchange with 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 rules.

In addition, the final rule codifies the following existing SEPs in an effort to provide clarity and certainty with regard to these rules:

- The SEP for dependents of Indians who are enrolled (or are enrolling) in a qualified health plan (QHP) through an Exchange at the same time as an Indian;
- The SEP for victims of domestic abuse or spousal abandonment (and their dependents) who seek to apply for coverage apart from the perpetrator of the abuse or abandonment;
- The SEP for consumers (and their dependents) who apply for coverage and are later determined ineligible for Medicaid or Children's Health Insurance Program (CHIP);
- The SEP that may be triggered by material plan or benefit display errors on the Exchange website (including errors related to service areas, covered services and premiums); and
- The SEP that may be triggered when a consumer resolves a data matching issue following the expiration of an inconsistency period.

The final rule also finalizes a separate interim final rule published on May 11, 2016, related to the SEP for individuals (and their dependents) who gain access to new QHPs as a result of a permanent move. The final rule generally adopts the interim final rule's amendments to this SEP to avoid abusive situations where individuals make a permanent move solely for the purpose of gaining health coverage in which they would otherwise not be qualified to enroll.

Specifically, the final rule requires individuals to be enrolled in minimum essential coverage for one or more days in the 60 days preceding the permanent move in order to qualify for the "permanent move" SEP. However, the final rule adopts the following three exceptions to this amended rule:

- Individuals previously living outside of the United States (or in a U.S. territory) who move to the United States are eligible for this SEP, so long as they seek to enroll in coverage within 60 days of completing their permanent move.
- Individuals who become newly eligible for a QHP due to a release from incarceration (other than incarceration pending disposition of charges) are eligible for this SEP.
- Individuals who lived in a state that did not expand Medicaid and were ineligible for Exchange subsidies because their income was below 100 percent of the federal poverty level, but who become newly eligible for subsidies as a result of a permanent move to another state are eligible for the SEP.

Enhanced Standards for State-based Exchanges on the Federal Platform

The 2017 Notice of Benefit and Payment Parameters added an additional Exchange model—**a state-based Exchange on the federal platform (SBE-FP)**—to enable SBEs to conduct certain processes using the federal eligibility and enrollment technology infrastructure on www.healthcare.gov. The 2017 final rule required SBE-FPs to enforce certain plan and issuer requirements that are no less strict than the requirements that HHS applies in the FFEs.

The 2018 final rule enhances this obligation, requiring SBE-FPs that use the federal platform for certain Small Business Health Options Program (SHOP) functions to establish standards and policies consistent with certain federally facilitated SHOP (FF-SHOP) requirements. Specifically, affected SBE-FPs must establish compliant standards and policies with respect to:

- Premium calculation, payment and collection requirements;
- The timeline for rate changes;
- Minimum participation rate requirements and calculation methodologies;
- Employer contribution methodologies;
- Annual employee open enrollment period requirements;
- Initial group enrollment or renewal coverage effective date requirements; and
- Termination of SHOP coverage or enrollment rules.

Standardized Exchange Plan Options

The 2017 Notice of Benefit and Payment Parameters established six standardized benefit plan options—called "**simple choice plans**"—in the individual market FFE to simplify the plan selection process by allowing consumers to more easily compare plans across issuers in the FFE. These standardized options include:

- One bronze standardized option;
- One silver standardized option;
- A separate standardized option for each silver plan variation (73 percent, 87 percent and 94 percent) available to individuals who are eligible for cost-sharing reductions; and
- One gold standardized option.

For 2018, the final rule provides the following **three new sets of six standardized options**:

- The first set of standardized options would be a version of the 2017 standardized plan options that have been updated to reflect modifications for 2016 enrollment weighted QHPs.
- The second set of standardized options is designed to work in states that: (1) require that cost-sharing for physical, occupational or speech therapy be no greater than the cost-sharing for primary care visits;

(2) limit the amount that can be charged for each drug tier; or (3) require that all drug tiers carry a copayment rather than coinsurance (Arkansas, Delaware, Iowa, Kentucky, Louisiana, Missouri, Montana and New Hampshire).

- The third set of standardized options is designed for New Jersey, which has maximum deductible requirements and other cost-sharing standards. (Some states also have oral chemotherapy mandates, but CMS believes that these are consistent with standardized plan options.)

Like the 2017 standardized options, the 2018 standardized options each have a single provider tier, fixed deductible, fixed annual cost-sharing limit, four drug tiers, and fixed copayment or coinsurance for a key set of EHB that comprise a large percentage of the total allowed costs for a typical population of enrollees. However, the 2018 final rule includes the following changes to comply with state law requirements on cost-sharing:

- The 2018 options at the **silver**, **silver cost-sharing reduction variations** and **gold** levels of coverage have separate medical and drug deductibles; and
- The standardized options at the **silver 87 percent cost-sharing reduction plan variation**, **silver 94 percent cost-sharing reduction plan variation** and **gold** levels of coverage have a $0 drug deductible (meaning no deductible applies to the drugs).

Each state would still only have one standardized option at each level of coverage. In addition, the 2018 rule also established a fourth **standardized health savings account (HSA)-eligible bronze high deductible health plan (HDHP) option** that would comply with IRS HSA rules.

Child Age Rating

The ACA allows premium rates to vary based on age within a ratio of 3 to 1 for adults. In addition, the ACA provides for uniform age bands, including a single age band for individuals age 0 through 20. However, this age rating structure for children has proved to be problematic, particularly when individuals reach age 21 (often resulting in significant premium increases at that time).

The final rule updates the child age rating structure in an effort to better reflect the health risk of children and to provide a more gradual transition when individuals move from age 20 to 21. Specifically, effective for plan or policy years beginning on or after Jan. 1, 2018, the final rule establishes:

- One age band for individuals age 0 through 14; and
- Single-year age bands for individuals age 15 through 20.

In addition, the final rule establishes child rating factors that, overall, are higher than the current child factor, and are intended to more accurately reflect health care costs for children.

Source: Department of Health and Human Services