TABLE 15—REDUCTIONS IN MAXIMUM ANNUAL LIMITATION ON COST SHARING FOR 2018

Eligibility category	Reduced maximum annual limitation on cost sharing for self-only coverage for 2018	Reduced maximum annual limitation on cost sharing for other than self-only coverage for 2018
Individuals eligible for cost-sharing reductions under § 155.305(g)(2)(i) (that is, 100–150 percent of FPL)	$2,450	$4,900
Individuals eligible for cost-sharing reductions under § 155.305(g)(2)(ii) (that is, 150–200 percent of FPL)	2,450	4,900
Individuals eligible for cost-sharing reductions under § 155.305(g)(2)(iii) (that is, 200–250 percent of FPL)	5,850	11,700

c. Levels of Coverage: Bronze Plans (§ 156.140)

Section 2707(a) of the PHS Act and section 1302 of the Affordable Care Act direct issuers of non-grandfathered health insurance in the individual and small group markets, including QHPs, to ensure that plans meet a level of coverage specified in section 1302(d)(1) of the Affordable Care Act. A plan's level of coverage, referred to as the plan's actuarial value, is determined on the basis of the essential health benefits provided to a standard population. Section 1302(d)(1) of the Affordable Care Act requires the level of coverage for a bronze plan to have an AV of 60 percent, a silver plan to have an AV of 70 percent; a gold plan to have an AV of 80 percent; and a platinum plan to have an AV of 90 percent. In addition, section 1302(d)(3) states that the Secretary is to develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates. Currently, § 156.140(c) permits a de minimis variation of +/¥ 2 percentage points.[54]

All plans subject to the annual limitation on cost sharing at section 1302(c) of the Affordable Care Act have a minimum level of generosity that limits the lowest AV that a plan can achieve. For instance, a plan with a deductible of $7,350 that is equal to the annual limitation on cost sharing of $7,350 (which is the proposed 2018 annual limitation on cost sharing) with no services covered until the deductible and annual limitation on cost sharing are met, other than preventive services required to be covered without cost sharing under section 2713 of the PHS Act and 45 CFR 147.130, has an AV of 58.54 percent based on the draft 2018 AV Calculator. Because of the annual limitation on cost sharing, the AV for this type of plan is within the de minimis range of a bronze level of coverage. This type of plan does not have first dollar coverage (except for certain required preventive services), and is not a HDHP under 26 U.S.C. 223(c)(2) eligible for use with a health savings account because the annual limit on cost sharing under the plan is likely higher than the annual out of pocket expense limit for HDHPs for 2018. Furthermore, the bronze plan described above is less generous than a catastrophic plan, because a catastrophic plan is required by section 1302(e)(1)(B) of the Affordable Care Act and § 156.155(a)(4) to provide at least three primary care visits before reaching the deductible.

We note that in future recalibrations of the AV Calculator, if claims costs increase faster than the annual limitation on cost sharing, issuers' flexibility in designing different bronze plans may be reduced. In order to address this difficulty in designing bronze plans that are at least as generous as catastrophic plans and meet the AV requirements using future AV Calculators, we propose to permit a broader de minimis range for bronze plans. The purpose of the current de minimis variation of +/¥ 2 percentage points is to give issuers the flexibility to set cost-sharing rates while ensuring consumers can easily compare plans of similar generosity. Thus, the de minimis range is intended to allow plans to float within a reasonable range and is not intended to freeze plan designs, which could prevent innovation in the market. However, we do recognize the unique challenges that may be posed for bronze plan designs under future AV Calculators, and we therefore propose to amend § 156.140(c) to increase the allowable de minimis range for bronze plans under certain circumstances.

Outside of HDHPs, which have separate cost-sharing requirements, under future AV Calculators, if actuarial values increase significantly, bronze plans may be required to limit the services for which the plan pays before the deductible is reached. Enrollment data from the FFEs show that consumers have a preference for plans that cover and pay for services below the deductible. Because we believe that the Affordable Care Act did not intend for bronze plans to be less generous than catastrophic plans, which are required to provide at least three primary care visits before the deductible, we believe that it is important to allow bronze plans to retain at least one service before the deductible. Therefore, through our authority under section 1302(d)(3) of the Affordable Care Act, which directs the Secretary to develop guidelines to provide for a de minimis variance in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates, and section 1321(a)(1)(A) and (D) of the Affordable Care Act, which allows the Secretary to issue regulations setting standards for meeting the requirements for the establishment and operation of Exchanges, as well as such other requirements as the Secretary determines appropriate, we propose to allow bronze plans that cover and pay for at least one major service before the deductible, other than preventive services (some of which are required by Federal laws and regulations to have zero cost sharing) to have an allowable variance in AV of +/¥ 2 percentage points and +5 percentage points. The purpose of this proposal is to ensure flexibility in bronze plan designs—particularly, to permit the design of bronze plans that will satisfy AV requirements and still remain at least as generous as catastrophic plans.

We therefore propose that the major services covered and paid for by the plan before the deductible that trigger the increased de minimis range be similar in scope and magnitude to the three primary care visits before the deductible required under catastrophic coverage. To permit issuers the flexibility to address enrollees' varying health needs, we propose that the major

[54] Under § 156.400, the de minimis variation for a silver plan variation means a single percentage point.

services an issuer may elect to cover and pay for before the deductible in order to access the broader de minimis range be: Primary care visits; specialist visits; inpatient hospital services; generic, specialty, or preferred branded drugs; or emergency room services. We selected these services as they can be used by individuals with a wide variety of conditions and they have a significant AV impact. We solicit comments on this proposal and the proposed definition of major services, as well as comments on whether any of these major services should be excluded from the list or other major services should added to this list. We also solicit comments on whether major services should be defined based on all or some of the service inputs listed in the AV Calculator. This policy does not exempt issuers from their obligations to comply with mental health and substance use disorder parity requirements, including the rule that a deductible cannot be applied to mental health or substance use disorder benefits in a classification unless it is no more restrictive than the predominant deductible applicable to substantially all medical/surgical benefits in the same classification.

We also propose that the major service covered and paid for before the deductible must apply a reasonable cost-sharing rate to the service to ensure that the service is reasonably covered. We also solicit comments on what should be considered a reasonable cost-sharing rate for the major service. Lastly, to ensure that a bronze plan can be as least as generous as a catastrophic plan, we propose that a bronze plan with at least three primary care services under the deductible would qualify as having a major service under the deductible.

In addition to ensuring that bronze plans can remain at least as generous as catastrophic coverage, we believe it is important to ensure that bronze plans can remain eligible to be HDHPs that may be paired with a health savings account. Therefore, we propose that if a bronze plan meets the Federal requirements to be an HDHP, the allowable variation in AV for those plans is ¥ 2 percentage points and +5 percentage points. These HDHPs would not be required to cover at least one major service before the deductible, outside of certain preventive services, to meet the requirements for the extended bronze plan de minimis range, but instead, these plans would be required to meet the requirements to be a HDHP within the meaning of 26 U.S.C. 223(c)(2), including the annual out-of-pocket expense limit for HDHPs. We solicit comments on this proposal.

We also seek comment on the proposed size of the de minimis range, which is proposed as ¥ 2 percentage points and +5 percentage points, and whether the +5 percentage points should be higher or lower. Based on our initial analysis of 2017 bronze plans submitted for QHP certification in the FFEs, most 2017 bronze plans are either HDHPs or are plans providing one of the major services defined above before deductible. We believe that this policy will not be disruptive to the current bronze plan market as it will allow more flexibility in designing bronze plans within the increased de minimis range as well as allow more options for issuers to leave 2017 cost-sharing structures unchanged.

In connection with the release of the proposed 2018 Payment Notice, we are also releasing the draft versions of the 2018 AV Calculator, including the 2018 AV Calculator Methodology and User Guide, for comment on the Center for Consumer Information and Insurance Oversight Web site.[55] As part of the draft 2018 AV Calculator, we added the option to calculate AV for a bronze plan with an extended de minimis range to align with this proposed policy. (We note that under this option, the AV Calculator will not automatically flag a plan in the bronze extended de minimis range that does not comply with the requirement to cover one major service before the deductible.) Our intention will be to align the final 2018 AV Calculator with any provisions that are finalized through this rulemaking.

d. Application to Stand-Alone Dental Plans Inside the Exchange (§ 156.150)

In the 2017 Payment Notice, we finalized § 156.150(a), which establishes a formula to increase the annual limitation on cost sharing for stand-alone dental plans. Specifically, we finalized that for plan years beginning after 2017, the annual limitation for an SADP for one covered child is $350 increased by the percentage increase of the consumer price index (CPI) for dental services for the year two years prior to the applicable plan year over the CPI for dental services for 2016; and, the annual limitation for an SADP for two or more covered children is twice that.

The formula increases the dollar limit for one covered child (currently set at $350) by the percentage increase of the CPI for dental services for the year two years prior to the applicable plan year over the CPI for 2016. For plan year 2018, the percentage increase of the CPI for dental services for the two years prior to the applicable plan year would be equal to the CPI for 2016, resulting in a zero percent increase for plan year 2018. Therefore, for plan year 2018, the dental annual limitation on cost sharing would be $350 for one child and $700 for one or more children. The annual limitation on cost sharing for plan year 2019 will be addressed in the annual HHS notice of benefit and payment parameters for the 2019 benefit year.

3. Qualified Health Plan Minimum Certification Standards

a. QHP Issuer Participation Standards (§ 156.200)

Section 156.200(c)(1) implements section 1301(a)(1)(C)(ii) of the Affordable Care Act to require as part of QHP participation standards that each QHP issuer offer at least one QHP in the silver coverage level and at least one QHP in the gold coverage level.

As evidenced by QHP application submissions to the FFEs, QHP issuers have generally interpreted this requirement to apply at the service area level, as opposed to at the Exchange level, meaning that an issuer must offer at least one QHP in the silver coverage level and at least one QHP in the gold coverage level throughout each service area in which it will offer a QHP through the Exchange (that is, one QHP that has an AV of 70 percent and one QHP that has an AV of 80 percent, plus or minus two percentage points). If the requirement were to be interpreted at the Exchange level, a QHP issuer could be in technical compliance with the requirement by offering one QHP in the silver coverage level and at least one QHP in the gold coverage level in a very limited service area, and not offer such coverage through the Exchange in a meaningful way. We believe that the Affordable Care Act did not intend to allow an issuer to offer a silver and gold QHP through the Exchange in merely one service area in a State, while offering other products through the Exchange, such as bronze or catastrophic QHPs, in other service areas. The proposal seeks to eliminate the possibility of such gaming. Provisions of the Affordable Care Act sought to ensure an adequate choice of QHPs and coverage to consumers. We are proposing this change to ensure that consumers have an adequate choice of QHPs at different coverage levels. Further, the Affordable Care Act also assumed calculation of the advance payment of the premium tax credit based on the availability of a second

[55] The draft 2018 AV Calculator and Methodology will be posted under the "Plan Management" section of CCIIO's Web site at: *https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html.*