Key Issue in CMS Proposal on 2018 Benefits and Parameters on Standardized Benefits

On September 6, 2016, CMS issued a proposed rule: Notice of 2018 Benefit and Payment Parameters for 2018. Most of the proposal applies only to federally facilitated exchanges and state-based exchanges relying on the federal website, but some also appear to apply to state-based exchanges as well.

A key change would **allow a broader range for the minimum actuarial value (AV) of bronze plans**, changes to the risk-adjustment program, and provisions for cost-sharing parameters and cost-sharing reductions. (For standardized plans at the federal level, the insurance marketplace (healthcare.gov) will offer four options for the bronze level, three for silver, and three for gold. Additionally, each state is required to have one standardized option for each metal level and plan variations that issuers would then be able to choose from. *However, this does not apply to rules regarding standardized plans offered in state-based exchanges.)*

More significant for DC, CMS proposes to change the *de minimus* AV range for bronze plans. Currently, evaluation of plans for a given metal level permit variation of $\pm$ 2 percent. To be a bronze plan, the AV must be between 58% and 62%, a silver plan must have AV between 68% and 72%, etc.

This notice proposes that bronze plans that cover and pay for at least one major service (with the exception of preventive services) before the deductible kicks in should have an allowable variance in AV of -2 percentage points to +5 percentage points, or 58% to 65%. It is further proposed that the major service(s) covered and paid for before applying the deductible should be similar in scope and magnitude to the three primary care visits under the deductible in catastrophic coverage plans. However, to permit flexibility when addressing the enrollees' health needs, the aforementioned major service(s) can fall under the range of any of the following: primary care visits, specialist visits, inpatient hospital services, generic, specialty, or preferred branded drugs, or emergency room services. It is also proposed that a reasonable cost-sharing rate be applied to the service to ensure that it is reasonably covered. Alternatively, a bronze plan with at least three primary care visits before charging a deductible would qualify as having at least one major service under the deductible. This provision will allow greater flexibility when designing standardized benefits at the bronze level and will ensure that they remain at least as generous as catastrophic plans.

Additionally, bronze plans that qualify as High-Deductible Health Plans (HDHP) under federal requirements will also have a variation in AV of -2 to +5 percentage points without being required to cover at least one major service under the deductible.