H. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Standardized Options (§ 155.20)

a. Standardized Options Approach for 2018

In the 2017 Payment Notice, HHS finalized six standardized options (also now referred to as Simple Choice plans), one at each of the bronze, silver, silver cost-sharing reduction variation, and gold levels of coverage, designed to be similar to the most popular (enrollment-weighted) QHPs in the 2015 individual market FFEs. We propose to change the standardized options from the 2017 versions in order to reflect changes in QHP enrollment-weighted data from 2015 to 2016, including SBE–FP QHP enrollment-weighted data, and to the extent practicable, to comply with various State cost-sharing standards. Therefore, for the 2018 plan year, HHS proposes three new sets of standardized options, based on an analysis of enrollment-weighted 2016 individual market FFE and SBE–FP QHPs (see Tables 12, 13 and 14). The second and third sets are different from the first set only to the extent necessary to comply with State cost-sharing laws. The second set of standardized options is designed to work in States that: (1) Require that cost sharing for physical therapy, occupational therapy, 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. The third set of standardized options is designed to work in a State with maximum deductible requirements and other cost-sharing standards.

Like the 2017 standardized options, the proposed 2018 standardized options each have a single provider tier, fixed deductible, fixed annual limitation on cost sharing, and fixed copayment or coinsurance for a key set of essential health benefits that comprise a large percentage of the total allowed costs for a typical population of enrollees. These fixed cost-sharing values are for in-network care only. Unlike the 2017 standardized options, the proposed 2018 options at the silver, silver cost-sharing reduction variations, and gold levels of coverage have separate medical and drug deductibles, reflecting the commonality of this cost-sharing structure in QHPs at these levels of coverage. The proposed 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 drug deductible equal to $0, meaning no deductible applies to the drugs.

The bronze standardized options as proposed rely on finalization of the proposal discussed in the preamble to § 156.140 to permit a broader de minimis range for bronze plans. If that proposal is not adopted, the plans would be revised to comply with the de minimis range in our regulations, while still reflecting 2016 enrollment weighted data, and State cost-sharing requirements for the second set of standardized options.

For 2018, we also propose a fourth standardized option at the bronze level of coverage that qualifies as a high deductible health plan (HDHP) under section 223 of the Code, eligible for use with a health savings account (HSA). HDHPs are an option valued by many consumers—enrollment in HDHPs across 2016 individual market FFE and SBE–FP QHPs constituted 9.2 percent of all FFE and SBE–FP QHP enrollment in 2016. Pursuant to the terms of the Code, the IRS releases the maximum annual limitation on cost sharing and minimum annual deductible for HDHPs annually in the spring, subsequent to the annual HHS notice of benefit and payment parameters rulemaking process. Therefore, we propose that if any changes to the HDHP standardized option would be required to reflect differences between the HDHP standardized option finalized in the 2018 Payment Notice and the subsequently released maximum annual limitation on cost sharing and minimum annual deductible for HDHPs, HHS would publish those changes in guidance. Accordingly, we propose to amend the definition of "standardized option" at § 155.20 to provide for a plan to be considered a standardized option if it is: (1) A QHP offered for sale through an individual market Exchange with a standardized cost-sharing structure specified by HHS in rulemaking; or (2) an HDHP QHP offered for sale through an individual market Exchange with a standardized cost-sharing structure specified by HHS in guidance issued solely to modify the cost-sharing structure specified by HHS in rulemaking to the extent necessary to align with requirements to qualify as an HDHP under section 223 of the Code and meet HHS AV requirements.

b. Standardized Options in SBE–FPs

In the 2017 Payment Notice, we designed a set of standardized options based on enrollment-weighted 2015 FFE QHP data, and indicated we anticipated differentially displaying these HHS-designed standardized options. We noted that SBE–FPs may have their own State-designed standardized plans that differ from HHS-designed standardized options, but that the *HealthCare.gov* platform would not be able to differentially display these State-designed standardized plans.

For 2018, the *HealthCare.gov* platform remains unable to provide differential display to State-designed standardized plans that differ from the HHS-designed standardized options. However, we propose that SBE–FPs may choose to allow HHS-designed standardized options to receive differential display on *HealthCare.gov*, just as the plans would if offered through an FFE. We propose that an SBE–FP must notify HHS if it wants HHS-designed standardized options to receive differential display by a date to be specified in guidance that will be set to provide sufficient time to operationalize the State's choice on *HealthCare.gov*. We seek comment on this proposal.

c. State Customization

In the 2017 Final Payment Notice, HHS explained that it would not be possible for *HealthCare.gov* to accommodate customization of standardized options by State in 2017. Specifically, to reduce operational complexity, HHS did not vary the standardized options by State or by region, and instead finalized one set of standardized options across all FFEs that issuers would have the option to offer in 2017.

As noted above, some States regulate cost sharing on specific benefits under State authorities. We seek to accommodate, to the extent practicable, State cost-sharing requirements under our proposed 2018 standardized options. To do so, we have designed three bronze standardized options (in addition to the bronze HDHP), and three standardized options at each of the silver, silver cost-sharing reduction plan variations, and gold levels of coverage, as set forth in Tables 13 and 14. We propose to select for each FFE State one of the three standardized options at each level of coverage (plus the HDHP option at the bronze level, if permissible under State cost-sharing standards) that meets any existing State cost-sharing requirements. We propose that this selection will be published in the final 2018 Payment Notice. We propose to do the same for each SBE–FP State that notifies HHS that it chooses to have HHS standardized options receive differential display on the *HealthCare.gov* platform. If issuers in the FFE States and those in the SBE–FP States that choose to have differential

display of HHS standardized options offer the standardized options selected for the State (that is, the one standardized option at each level of coverage selected for the State, in addition to the HDHP option if permissible under State standards), those plans would receive differential display in the Exchange for the 2018 plan year.

Additionally, many States have oral chemotherapy access laws, which require coverage of oral chemotherapy at parity with intravenous chemotherapy or cap patients' monthly cost sharing for chemotherapy drugs (both oral and intravenous). We propose to clarify that these chemotherapy access requirements do not conflict with the HHS standardized plan designs because issuers can design benefit packages that comply with both the standardized options requirements and State oral chemotherapy access laws.

We believe that the proposals discussed above will allow issuers in States with cost-sharing laws that would conflict with a single set of standardized options to offer standardized options. Furthermore, by making it possible for issuers to offer standardized options while complying with State cost-sharing rules, we believe this limited State customization will enhance the shopping experience of consumers in more States than was previously possible. We welcome comments from each State regarding the standardized option at each level of coverage that the State believes would be most suitable for that State, and whether modifications should be made to any of the proposed State-customized standardized options to further accommodate State cost-sharing rules. We also seek comment from States, issuers, and other stakeholders on State cost-sharing requirements that would affect the design of standardized options, as well as comments generally on this approach for standardized options in 2018.

TABLE 12—2018 PROPOSED STANDARDIZED OPTIONS

	Bronze	HSA-eligible bronze HDHP	Silver	Silver 73% CSR plan variation	Silver 87% CSR plan variation	Silver 94% CSR plan variation	Gold
Actuarial Value (%)	62.68%	61.97%	71.05%	73.95%	87.61	94.69	80.65%.
Deductible (Med/Rx)	$6,650	$6,000	$3,500/$500	$3,000/$200	$700/$0	$250/$0	$1,400/$0.
Annual Limitation on Cost Sharing.	$7,350	$6,000	$7,350	$5,850	$2,450	$1,250	$5,000.
Emergency Room Services.	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Urgent Care	$75 (*)	No charge after deductible.	$75 (*)	$75 (*)	$40 (*)	$25 (*)	$60 (*).
Inpatient Hospital Services	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Primary Care Visit	$35 (*)	No charge after deductible.	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Specialist Visit	$75 (*)	No charge after deductible.	$65 (*)	$65 (*)	$25 (*)	$10 (*)	$50 (*).
Mental Health/Substance Use Disorder Outpatient Office Visit.	$35 (*)	No charge after deductible.	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Imaging (CT/PET Scans, MRIs).	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Speech Therapy	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Occupational Therapy/ Physical Therapy.	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Laboratory Services	40%	No charge after deductible.	20%	20%	20%	5%	20%.
X-rays and Diagnostic Imaging **.	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Skilled Nursing Facility	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Outpatient Facility Fee (for example, Ambulatory Surgery Center).	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Outpatient Surgery Physician/Surgical Services.	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Generic Drugs	$35 (*)	No charge after deductible.	$15 (*)	$15 (*)	$5 (*)	$3 (*)	$10 (*).
Preferred Brand Drugs	35%	No charge after deductible.	$50 (*)	$50 (*)	$25 (*)	$5 (*)	$40 (*).
Non-Preferred Brand Drugs.	40%	No charge after deductible.	$100 (*)	$100 (*)	$50 (*)	$10 (*)	$75 (*).
Specialty Drugs	45%	No charge after deductible.	40%	40%	30%	25%	30%.

(*) = not subject to the deductible

** **Note:** Excludes x-rays and diagnostic imaging associated with office visits (except for high-deductible health plans (HDHPs).

TABLE 13—2018 PROPOSED STANDARDIZED OPTIONS FOR STATES REQUIRING OCCUPATIONAL THERAPY, PHYSICAL THERAPY, OR SPEECH THERAPY COST-SHARING PARITY WITH PRIMARY CARE VISITS OR STATES REQUIRING COPAYMENTS OR COPAYMENT LIMITS ON DRUGS

	Bronze	Silver	Silver 73% CSR plan variation	Silver 87% CSR plan variation	Silver 94% CSR plan variation	Gold
Actuarial Value (%)	62.79%	71.03%	73.88%	87.70	94.68	80.60%.
Deductible (Med/Rx)	$6,650	$3,500/$500 Rx	$3,000/$200 Rx	$700/$0	$250/$0	$1,400/$0.
Annual Limitation on Cost Sharing.	$7,350	$7,350	$5,850	$2,450	$1,250	$5,000.
Emergency Room Services.	40%	20%	20%	20%	5%	20%.
Urgent Care	$75 (*)	$75 (*)	$75 (*)	$40 (*)	$25 (*)	$60 (*).
Inpatient Hospital Services.	40%	20%	20%	20%	5%	20%.
Primary Care Visit	$35 (*)	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Specialist Visit	$75 (*)	$65 (*)	$65 (*)	$25 (*)	$10 (*)	$50 (*).
Mental Health/Substance Use Disorder Outpatient Office Visit.	$35 (*)	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Imaging (CT/PET Scans, MRIs).	40%	20%	20%	20%	5%	20%.
Speech Therapy	$35 (*)	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Occupational Therapy/Physical Therapy.	$35 (*)	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Laboratory Services	40%	20%	20%	20%	5%	20%.
X-rays and Diagnostic Imaging**.	40%	20%	20%	20%	5%	20%.
Skilled Nursing Facility	40%	20%	20%	20%	5%	20%.
Outpatient Facility Fee (e.g., Ambulatory Surgery Center).	40%	20%	20%	20%	5%	20%.
Outpatient Surgery Physician/Surgical Services.	40%	20%	20%	20%	5%	20%.
Generic Drugs	$35 (*)	$15 (*)	$15 (*)	$5 (*)	$3 (*)	$10 (*).
Preferred Brand Drugs	$40 (copay applies only after deductible).	$50 (*)	$50 (*)	$25 (*)	$5 (*)	$40 (*).
Non-Preferred Brand Drugs.	$45 (copay applies only after deductible).	$100 (*)	$100 (*)	$50 (*)	$10 (*)	$75 (*).
Specialty Drugs	$50 (copay applies only after deductible).	$150 (copay applies only after deductible).	$150 (copay applies only after deductible).	$75 (*)	$20 (*)	$100(*).

(*) = not subject to the deductible.
**Note: Excludes x-rays and diagnostic imaging associated with office visits.

TABLE 14—2018 PROPOSED STANDARDIZED OPTIONS FOR STATES WITH DEDUCTIBLE MAXIMUMS AND OTHER COST-SHARING REQUIREMENTS

	Bronze	Silver	Silver 73% CSR plan variation	Silver 87% CSR plan variation	Silver 94% CSR plan variation	Gold
Actuarial Value (%)	64.84%	70.28%	73.94%	87.61%	94.53%	80.80%.
Deductible	$3,000	$3,000	$3,000	$700	$250	$1,000.
Annual Limitation on Cost Sharing	$7,150	$7,000	$5,850	$2,450	$1,250	$5,000.
Emergency Room Services	50%	40%	20%	20%	5%	30%.
Urgent Care	$50 (*)	$50 (*)	$50 (*)	$40 (*)	$25 (*)	$40 (*).
Inpatient Hospital Services	$500 (per day; applies only after deductible).	40%	20%	20%	5%	30%.
Primary Care Visit	$35 (*first 3 visits; then subject to deductible and $35 copay after deductible).	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$25 (*).
Specialist Visit	$75 (applies only after deductible).	$60 (*)	$60 (*)	$25 (*)	$10 (*)	$40 (*).
Mental Health/Substance Use Disorder Outpatient Office Visit.	$35 (applies only after deductible).	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$25 (*).
Imaging (CT/PET Scans, MRIs)	$100 (applies only after deductible).	$100 (*)	$100 (*)	$75 (*)	$40 (*)	$100 (*).
Speech Therapy	$35 (applies only after deductible).	$50 (*)	$30 (*)	$10 (*)	$5 (*)	$25 (*).
Occupational Therapy/Physical Therapy.	$35 (applies only after deductible).	$50 (*)	$30 (*)	$10 (*)	$5 (*)	$25 (*).

TABLE 14—2018 PROPOSED STANDARDIZED OPTIONS FOR STATES WITH DEDUCTIBLE MAXIMUMS AND OTHER COST-SHARING REQUIREMENTS—Continued

	Bronze	Silver	Silver 73% CSR plan variation	Silver 87% CSR plan variation	Silver 94% CSR plan variation	Gold
Laboratory Services	50%	40%	20%	20%	5%	30%.
X-rays and Diagnostic Imaging**	50%	40%	20%	20%	5%	30%.
Skilled Nursing Facility	$500 (per day; applies only after deductible).	40%	20%	20%	5%	30%.
Outpatient Facility Fee (e.g., Ambulatory Surgery Center).	50%	40%	20%	20%	5%	30%.
Outpatient Surgery Physician/Surgical Services.	50%	40%	20%	20%	5%	30%.
Generic Drugs	$25 (*)	$25 (*)	$15 (*)	$5 (*)	$3 (*)	$10 (*).
Preferred Brand Drugs	50%	$75 (*)	$75 (*)	$25 (*)	$5 (*)	$25 (*).
Non-Preferred Brand Drugs	50%	$75 (*)	$75 (*)	$50 (*)	$10 (*)	$50 (*).
Specialty Drugs	50%	$75 (*)	$75 (*)	$50 (*)	$10 (*)	$50 (*).

(*) = not subject to the deductible
** Note: Excludes x-rays and diagnostic imaging associated with office visits.

2. General Functions of an Exchange

functions. Additionally, requiring

using the Federal platform for SHOP