Issue Brief

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CMS Issues Final Notice of Benefit and Payment Parameters for 2019

The Centers for Medicare & Medicaid Services issued a final Notice of Benefit and Payment Parameters for 2019. A copy of the 523-page rule is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07355.pdf. Publication is scheduled in the ***Federal Register*** for Tuesday, April 17. Please note the document currently is listed in the ***Federal Register*** inspection site under HHS and not under CMS.

According to CMS, "The final rule is intended to advance the Administration's goals for increasing flexibility, improving affordability, strengthening program integrity, empowering consumers, promoting stability and reducing unnecessary regulatory burdens associated with the Patient Protection and Affordable Care Act (the Affordable Care Act) in the individual and small group health insurance markets."

This final rule sets forth payment parameters and provisions related to the risk adjustment and risk adjustment data validation programs, cost-sharing parameters, and user fees for Federally-facilitated Exchanges and State Exchanges on the Federal platform. It finalizes changes that provide additional flexibility to states to apply the definition of essential health benefits to their markets, enhance the role of states regarding the certification of qualified health plans, and provide states with additional flexibility in the operation and establishment of Exchanges, including the Small Business Health Options Program Exchanges. It includes changes to standards related to Exchanges, the required functions of the SHOPs, actuarial value for stand-alone dental plans, the rate review program, the medical loss ratio program, eligibility and enrollment, exemptions, and other related topics.

CMS also has issued the following items.

- A Final Annual Issuer Letter. This letter provides operational and technical guidance to issuers that want to offer Qualified Health Plans in the Federally-facilitated Exchanges for plan years beginning in 2019. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#Health Insurance Marketplaces
- New guidance expanding hardship exemptions. Under this hardship exemption guidance, individuals who live in counties with no issuers or only one issuer, will now qualify for a hardship exemption from paying the Affordable Care Act's penalty for not having coverage (until the penalty expires next year). The guidance also allows CMS to consider a broad range of circumstances that result in consumers needing hardship exemptions. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2018-Hardship-Exemption-Guidance.pdf

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- A bulletin to extend the transition to fully Affordable Care Act compliant coverage in the individual and small group health insurance markets until 2019. CMS is releasing this bulletin to provide states additional flexibility and control over their health insurance markets. https://www.cms.gov/cciio/resources/regulations-and-guidance/#Health%20Insurance%20Market%20Reforms/

Comment

This is another recent rule aimed primarily at the insurance market. Much of the material that follows is excerpted from CMS' fact sheets. Those requiring more in-depth detailed information should review the rule itself.

INCREASING FLEXIBILITY

CMS is providing states with additional flexibility in how they select their EHB-benchmark plan for plan years 2020 and beyond, and is providing states with additional choices with respect to benefits and affordable coverage. Instead of being limited to 10 options, states will be allowed to:

- choose from one of the 50 EHB-benchmark plans that other states used for the 2017 plan year;
- replace one or more of the 10 required EHB categories of benefits under its EHB-benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year (for example, a state may select the prescription drug coverage EHB category from another state's EHB-benchmark plan used for the 2017 plan year and the hospitalization EHB category from a third state's EHB-benchmark plan used for the 2017 plan year); or
- otherwise select a set of benefits to become its EHB-benchmark plan, provided the EHB-benchmark meets the scope of benefits requirements and other specified requirements.

These three options are subject to additional requirements, including two scope of benefits conditions.

First, consistent with the ACA, the EHB-benchmark plan must provide a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category, the scope of benefits provided under a typical employer plan. The final rule defines a typical employer plan as either:

- one of the selecting state's 10 base-benchmark plan options established at §156.100 from which the state could select for the 2017 plan year; or
- the largest health insurance plan by enrollment in any of the five largest large group health insurance products by enrollment in the selecting state, as product and plan are defined at §144.103, provided that: a) the product has at least 10 percent of the total enrollment of the five largest large group health insurance products by enrollment in the selecting state; b) the plan provides minimum value; c) the benefits are not excepted benefits; and d) the benefits in the plan are from a plan year beginning after Dec. 31, 2013.

Second, the state's EHB-benchmark plan must not exceed the generosity of the most generous among a set of comparison plans, including the EHB-benchmark plan used by the state in 2017, and any of the state's base-benchmark plan options for the 2017 plan year, supplemented as necessary.

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STANDARDIZED OPTIONS

CMS is not specifying standardized options for the 2019 plan year. In the 2017 Payment Notice, CMS introduced standardized options to specify QHP designs that different insurers could provide using the same standardized cost-sharing structure, including the same deductible, co-pay and coinsurance rates.

For 2017 and 2018 plan years, HHS encouraged issuers to offer standardized plans and highlighted these plans on HealthCare.gov by providing them a differential display. CMS will not be encouraging standardized options or providing differential display of standardized options on HealthCare.gov for 2019. Agents, brokers and issuers that assist consumers with QHP selection and enrollment also will not be required to provide differential display of standardized options. CMS says it heard concerns that providing differential display for these plans may limit enrollment in coverage with plan designs that do not match the standardized options, removing incentives for issuers to offer coverage with innovative plan designs.

QUALIFIED HEALTH PLAN CERTIFICATION STANDARDS

CMS is returning important oversight authority back to the states by expanding their role in the QHP certification process for Federally-facilitated Exchanges. CMS will continue to defer to the states' reviews of network adequacy provided the state has a sufficient network adequacy review process for plan years 2019 and beyond. CMS had previously introduced this approach in the Market Stabilization rule; however, it only impacted plan year 2018.

In addition, CMS is eliminating requirements for State-based Exchanges using the Federal Platform to enforce FFE standards for network adequacy and essential community providers. Instead, CMS is allowing SBE-FPs the flexibility to establish their own standards, which CMS believes will further empower SBE-FPs to use their QHP certification authority to encourage issuers to stay in the Exchange, enter the Exchange for the first time or expand into additional service areas.

CMS also is eliminating the meaningful difference requirement for QHPs. The meaningful difference standard was implemented to make it easier for consumers to understand differences between plans, and choose the right plan option for them. However, with fewer issuers participating in the Exchanges and fewer plans for consumers to choose from, CMS is removing these standards, saying they are no longer necessary.

NAVIGATOR PROGRAM

CMS is providing Exchanges with more flexibility in the operation of Navigator programs by removing the requirements that each Exchange must have at least two Navigator entities, and that one of these entities must be a community and consumer-focused nonprofit group. Also, CMS is removing the requirement that each Navigator entity maintain a physical presence in the Exchange service area.

RISK ADJUSTMENT

CMS is amending the HHS-operated risk adjustment program in three ways. First, the risk adjustment model for the 2019 benefit year will be recalibrated using blended coefficients from the 2016 enrollee-level External Data Gathering Environment data and 2014 and 2015 MarketScan® data.

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Second, CMS is removing two severity-only drug classes from the 2019 benefit year risk adjustment models that no longer meaningfully predict incremental risk.

Third, in states where HHS operates the risk adjustment program, CMS will provide states with the flexibility to request a reduction to the otherwise applicable risk adjustment transfers in the individual, small group or merged market by up to 50 percent beginning with the 2020 benefit year. States requesting such a reduction must provide supporting evidence and analysis that show the state-specific rules or market dynamics warrant an adjustment to more precisely account for the relative risk differences in the state's market, and justify the reduction amount requested.

IMPROVING AFFORDABILITY EXEMPTIONS

Exchanges will be able to make a determination of lack of affordable coverage based on projected income using the lowest cost Exchange metal level plan offered through the Exchange when there is no bronze level plan available in the service area.

STAND ALONE DENTAL PLAN ACTUARIAL VALUE

CMS is removing the actuarial value levels of coverage standard for stand-alone dental plans in the Exchanges that required SADPs to cover pediatric dental EHB at one of two AV levels – either a low (70 percent +/- 2 percentage points) or high (85 percent +/- 2 percentage points) AV level. The ACA does not specifically require SADP issuers to offer coverage at the high or low levels of AV. CMS notes that by removing the AV level requirement, SADP issuers will have the opportunity to offer more flexible plan designs to consumers.

STRENGTHENING PROGRAM INTEGRITY VERIFICATION FOR ELIGIBILITY FOR INSURANCE AFFORDABILITY PROGRAMS

To promote program integrity, CMS will generate annual income inconsistencies for certain consumers who attest to income that is higher than the amount found in income data received from the Exchange's trusted data sources (Internal Revenue Service and the Social Security Administration, or other current income data sources) by more than a reasonable threshold amount. This new check only will be for households for which trusted data sources reflect income below 100 percent FPL, because an accurate eligibility determination is critical for consumers near this threshold to ensure that advance payment of the premium tax credit is not paid on behalf of consumers who are statutorily ineligible. CMS also is modifiying the requirements for Exchanges to verify eligibility for, and enrollment in, qualifying employer-sponsored coverage, such that Exchanges will continue to have the option to conduct an alternative process to sampling for benefit years through 2019.

To further promote program integrity, CMS is removing the requirement prohibiting Exchanges from discontinuing APTC because the tax filer has failed to file a tax return and reconcile APTC paid for past benefit years, if the Exchange does not first send notice directly to the tax filer. Adequate notice and the opportunity for the tax filer to correct the issue is still required, but CMS believes this is an important program integrity measure to help ensure that APTC is not paid on behalf of enrollees and tax filers who are not eligible due to failure to file and reconcile.

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HHS-RISK ADJUSTMENT DATA VALIDATION REQUIREMENTS

CMS is finalizing several changes to HHS-RADV requirements to ensure the integrity of results while, at the same time, reducing unnecessary regulatory burdens on insurers. In states where CMS operates the risk adjustment program, CMS performs RADV audits to validate the accuracy of the diagnosis codes submitted by issuers to their respective EDGE servers for the risk adjustment transfer calculation. CMS changes to HHS-RADV include the following.

- implementing a simplified approach to making payment adjustments as a result of HHS-RADV error rates that only will adjust an issuer's risk score when the error rate for a group of hierarchical condition categories is an outlier relative to the error rates for that group of HCCs for all issuers in HHS-RADV for the benefit year being validated;
- requiring post-transfer adjustments to payment transfers based on the results of the HHS-RADV for insurers that have exited the market;
- exempting issuers with 500 or fewer billable member months statewide from the requirement to hire an initial validation auditor submit initial validation audit results, or be subject to risk adjustment data validation payment adjustments;
- changing the data sampling methodology so that the initial sample only would include enrollees from state risk pools with more than one issuer;
- modifying the minimum data elements required for validation of mental or behavioral health diagnoses to address state law privacy concerns;
- adding the 2016 benefit year as an initial year of HHS-RADV for which the initial validation auditor may meet an inter-rater reliability standard of 85 percent versus the higher 95 percent standard;
- clarifying and amending the bases upon which civil money penalties may be imposed for violation of HHS-RADV requirements;
- providing that demographic or enrollment errors discovered during HHS-RADV would be the basis for an adjustment to the applicable benefit year transfer amount, rather than the subsequent benefit year risk score; and
- postponing the applicability of the HHS-RADV materiality threshold to begin with the 2018 benefit year, instead of the 2017 benefit year.

EMPOWERING CONSUMERS SPECIAL ENROLLMENT PERIODS

CMS is aligning the enrollment options for all dependents who are newly enrolling in Exchange coverage through an SEP and are being added to an application with current enrollees, regardless of the SEP under which the dependent qualifies. CMS also is amending and standardizing the alternate coverage start date options available to consumers newly gaining or becoming a dependent and enrolling due to a birth, adoption, foster care placement or court order. CMS will allow pregnant women who are receiving health care services through Children's Health Insurance Program coverage for their unborn child to qualify for a loss of coverage SEP upon losing access to this coverage. Finally, CMS exempts consumers from the prior coverage requirement that applies to certain special enrollment periods if they lived in a service area without qualified health plans available through an Exchange during a recent enrollment period for which they were eligible.

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TERMINATION EFFECTIVE DATES

The rule will make it simpler for consumers to terminate coverage through the Exchanges, by, at the option of the Exchange, allowing enrollees to request same-day or prospective coverage termination dates. Previously, most enrollees had to give a 14-day advance notice prior to termination. The rule also aligns termination effective dates for new Medicaid/CHIP enrollees to this same timeline.

PROMOTING STABILITY MEDICAL LOSS RATIO

The final rule amends MLR requirements to reduce regulatory burdens to stabilize insurance markets, increase insurer participation and expand consumer choice. To start, CMS reduces the burden associated with the Quality Improvement Activity reporting requirements by allowing issuers the option to either continue tracking and reporting actual QIA expenses or report a standardized amount equal to 0.8 percent of the issuer's earned premium for the year for a minimum of three consecutive MLR reporting years without having to separately track such expenses.

The rule also modifies the information a state must provide to justify a request to adjust the 80 percent MLR standard in the individual market. The final rule amends various provisions to provide more flexibility to states by permitting requests for adjustments to the individual market MLR standard in any state that demonstrates that a lower MLR standard could help stabilize its individual market, and to streamline the process for applying for such adjustments to reduce burdens for states and CMS.

FFE AND SBE-FP USER FEES

CMS is maintaining the user fee rate at 3.5 percent of premium for FFEs and setting the user fee for SBE-FPs at 3.0 percent of premium for the 2019 benefit year. The SBE-FP user fee rate represents an increase for SBE-FP states from 2.0 percent established for the 2018 benefit year.

REDUCING UNNECESSARY REGULATORY BURDENS SMALL BUSINESS HEALTH OPTIONS PROGRAM

CMS is streamlining the Small Business Health Options Program enrollment process in the SHOP Exchanges using the Federal platform for employers to use an issuer-based enrollment approach. This change allows SHOPs to eliminate the online enrollment process and allows employers to enroll directly with an Exchange-registered agent, broker or issuer. SHOP Exchanges are no longer required to provide employee eligibility, premium aggregation and online enrollment functionality, and for plan years beginning on or after Jan. 1, 2018, FF-SHOPs and SBE-FP for SHOP will no longer be providing these services. The Small Business Health Care Tax Credit will continue to be available to employers who enroll their small group in a SHOP plan.

MINIMUM ESSENTIAL COVERAGE RECOGNITION FOR CHIP BUY-IN PROGRAMS

CMS did not finalize the proposed categorical designation of CHIP buy-in programs that provide identical coverage to the state's Title XXI CHIP program as minimum essential coverage since they

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have recently been statutorily designed as MEC. CMS will verify the MEC status of CHIP buy-in programs for states that submit plan documentation for the CHIP buy-in program and the state's Title XXI program to CMS for comparison. This optional verification will provide clarity for states and consumers and alleviate burdens on states.

RATE REVIEW

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

CMS makes several changes related to rate review to reduce regulatory burden for states and issuers by recognizing the primary role of state regulators in the rate review process. These changes include the following.

- exempting student health insurance coverage from the Federal rate review process;
- increasing the default threshold for rate increases subject to review to 15 percent from 10 percent;
- allowing states with Effective Rate Review Programs to have different submission deadlines for issuers that only offer non-QHPs; and
- reducing the advanced notification that states must give CMS about the posting of rate increases from 30 days to five business days if the state will be posting prior to the date specified by CMS.