Proposed 2019 Benefit Payment and Parameters Rule

The Centers for Medicare & Medicaid Services (CMS) released a proposed rule and fact sheet for the 2019 Benefit Payment and Parameters.

According to CMS, the proposed rule is intended to increase individual market flexibility, improve program integrity, and reduce regulatory burdens associated with the Patient Protection and Affordable Care Act (ACA) in many ways, including updates and annual provisions to:

- Essential Health Benefits
- State-Based Exchanges
- Small Business Health Options Program (SHOP)
- Qualified Health Plan (QHP) Certification Standards
- Standardized Options
- Stand-alone Dental Plans (SADP) Actuarial Value
- Navigator Program
- Risk Adjustment
- Special Enrollment Periods (SEPs)
- Verification for Eligibility for Insurance Affordability Programs
- Exemptions
- Termination Effective Dates
- Rate Review
- Medical Loss Ratio (MLR)
- Minimum Essential Coverage (MEC) Designation for CHIP Buy-In Program

CMS usually finalizes the Benefit Payment and Parameters rule in the first quarter of the year following the proposed rule's release. November 27, 2017, is the due date for public comments on the proposed rule.

The 2019 open enrollment period will run from November 1, 2018, to December 15, 2018.

Almost all the topics addressed in the proposed rule would affect the individual market and the Exchanges, particularly the Small Business Health Options Program (SHOP) Exchanges.

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Of interest to small group health plans, CMS proposes to change the way states will select essential health benefits benchmark plans. If CMS keeps this change in its final rule, then it will affect non-grandfathered small group health plans for benefit years 2019 and beyond.

Essential Health Benefits

Under the Public Health Service Act (PHS Act), as added by the ACA, health insurance issuers that offer non-grandfathered health insurance coverage in the individual or small group market must ensure that the coverage includes the Essential Health Benefits (EHB) package. Among other items, EHB package must include coverage of certain items and services within 10 categories and the EHB package's scope for those 10 EHB categories must be equal to the scope of benefits provided under a typical employer plan.

The U.S. Department of Health and Human Services (HHS) defines EHB based on a benchmark approach that allows states to select from one of 10 base-benchmark plans, including the largest health plan by enrollment in any of the three largest small group insurance products by enrollment, any of the largest three employee health benefit plan options by enrollment offered and generally available to state employees in the state, any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible federal employees, or the coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the state.

CMS proposes to give states additional flexibility in their selection of an EHB-benchmark plan for plan year 2019 and later plan years. CMS proposes that a state may change its EHB-benchmark plan by:

- Selecting the EHB-benchmark plan that another state used for the 2017 plan year;
- Replacing one or more EHB categories of benefits in 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; or
- Selecting a set of benefits that would become the state's EHB-benchmark plan if the EHB-benchmark plan does not provide more benefits than a comparison set of plans and is equal to the scope of benefits provided under a typical employer plan.

Under the proposed rule, a state's current EHB-benchmark plan selection would continue to apply for any year that the state does not select a new EBH-benchmark plan.

CMS is also considering establishing a federal default definition of EHB.

State-Based Exchanges

The ACA allows each state to operate its own state-based exchange (SBE). Currently, 11 states and the District of Columbia operate their own exchanges, 5 states use the state-based exchange on the federal platform (SBE-FP) model, and the federal facilitated exchanges (FFEs) operate in the remaining 34 states.

CMS proposes to explore strategies to:

- Increase program flexibility to help support the retention and financial self-sustainability of states participating in the SBE model
- Make the SBE-FP model more appealing and viable to states with FFEs
- Support retention of existing SBE-FPs

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Small Business Health Options Program (SHOP)

CMS proposes changes to remove several SHOP requirements related to online SHOP Exchange enrollment. CMS proposes an approach for SHOP Exchanges through which groups could enroll through a SHOP qualified health plan (QHP) issuer or a SHOP-registered agent or broker.

CMS proposes to remove many federal platform services currently available to a state operating an SBE-FP, including employee eligibility, enrollment, and premium aggregation services. This means that states operating an SBE-FP for SHOP would no longer be able to use the federal platform for these functions.

The Small Business Health Care Tax Credit would continue to be available to employers who enroll their small group in a SHOP plan.

If CMS' proposed changes to SHOP are finalized, then the changes would be effective on the final rule's effective date for plan years beginning on or after January 1, 2018.

Qualified Health Plan (QHP) Certification Standards

CMS proposes to streamline the qualified health plan (QHP) certification process for states by identifying areas where states are already performing reviews that are duplicative of the federal QHP certification process by:

- Relying on states' reviews in states where an FFE is operating if the state has a sufficient network adequacy review process (and relying on an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity for states that do not have the authority and means to conduct sufficient network adequacy)
- Deferring to states for certain accreditation requirements, certain compliance reviews, minimum geographic area of the plan's service area, and quality improvement strategy reporting as feasible and appropriate

Standardized Options

In HHS' 2017 Payment Notice, HHS introduced standardized options (also now referred to as Simple Choice plans). A standardized option is a QHP offered for sale through an individual market Exchange that either has a standardized cost-sharing structure specified by HHS, or has a standardized cost-sharing structure specified by HHS that is modified to align with high deductible health plan (HDHP) requirements or the applicable annual limitation on cost sharing and HHS actuarial value requirements.

For the 2017 and 2018 benefit years, HHS specified standardized options in rulemaking, encouraged issuers to offer such plans, and provided differential display of these plans on HealthCare.gov.

CMS proposes to not specify any standardized options for the 2019 benefit year and to not provide differential display for standardized options on HealthCare.gov. Further, CMS proposes that agents, brokers and issuers that assist consumers with QHP selection and enrollment would not be required to provide differential display for standardized options on their third-party websites.

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Stand-Alone Dental Plans (SADPs) Actuarial Value

The ACA directs the HHS Secretary to issue regulations on the calculation of actuarial value (AV) and its application to coverage levels. HHS finalized requirements for calculation of AV for stand-alone dental plans (SADPs) in its 2013 EHB rule.

CMS proposes to remove the AV standard for SADPs. SADP issuers would offer the pediatric dental EHB without selecting or calculating an AV level of that coverage. To be certified as QHPs, SADP issuers would continue to provide the pediatric dental EHB and continue to be held to the annual limitation on cost sharing for the pediatric EHB.

Navigator Program

The ACA requires each Exchange to establish a Navigator program under which it allows entities to, among other things, conduct public education activities to raise awareness of the availability of QHPs, distribute fair and impartial information concerning enrollment in QHPs and the availability of premium tax credits and cost-sharing reductions (CSRs), and facilitate enrollment in QHPs.

Currently, each Exchange must include among its Navigator grantees both a community and consumer-focused nonprofit group and at least one other entity listed with the regulation.

CMS proposes to amend the regulation to remove the requirements that each Exchange must have at least two Navigator entities and that at least one of these must be a community and consumer-focused nonprofit group.

CMS also proposes to remove the requirement that each Navigator must maintain a physical presence in the Exchange service area so that face-to-face assistance can be provided to applicants and enrollees.

Risk Adjustment

CMS proposes to amend the HHS risk adjustment model in the following ways:

- To use the 2014 and 2015 MarketScan® data and the 2016 enrollee-level EDGE data to recalibrate the 2019 risk adjustment model to provide more stability and predictability for issuers.
- To permit states to reduce the magnitude of risk adjustment transfers in the small group market to minimize unnecessary burden.
- To remove two severity-only drug classes from the model.

Special Enrollment Periods (SEPs)

For many special enrollment periods (SEPs), a dependent of an Exchange enrollee may newly enroll in Exchange coverage or switch Exchange plans when the dependent or another qualified individual on the Exchange application qualifies for a special enrollment period.

CMS has determined that, even though dependents may access SEPs based on different qualifying events, when they qualify for an SEP to newly enroll in Exchange coverage, regardless of whether it is an SEP due to gaining or becoming a dependent or due to a loss of minimum essential coverage, the dependents should be treated alike.

CMS proposes to align 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.

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For consumers newly gaining or becoming a dependent and enrolling through the birth, adoption, foster care placement, or court order SEPs, CMS proposes to amend and standardize the alternate coverage start date options available under all these SEPs.

CMS proposes to allow pregnant women who are receiving health care services through Children's Health Insurance Program (CHIP) coverage for their unborn child to qualify for a loss-of-coverage SEP upon losing access to this coverage.

CMS also proposes to exempt consumers from the prior coverage requirement that applies to certain SEPs if they lived in a service area without qualified health plans available through an Exchange.

Verification for Eligibility for Insurance Affordability Programs

CMS proposes to newly 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 (IRS and the Social Security Administration, or other current income data sources) by more than a reasonable threshold amount.

This new check would only be for households for which trusted data sources reflect income below 100 percent of the federal poverty level (FPL), because an accurate eligibility determination is critical for consumers near this threshold to ensure that advance premium tax credit (APTC) is not paid on behalf of consumers who are statutorily ineligible.

CMS also proposes to modify the requirements for Exchanges to verify eligibility for and enrollment in qualifying employer-sponsored coverage so that Exchanges would continue to have the option to conduct an alternative process to sampling for benefit years through 2019.

Exemptions

The ACA allows individuals to seek an exemption from the individual shared responsibility provision due to lack of affordable coverage based on an individual's projected income. Among other standards, when determining whether affordable coverage is available for individuals not eligible for employer-sponsored coverage, the Exchange should use the annual premium for the lowest-cost bronze plan available in the individual market through the Exchange in the state in the rating area in which the individual resides.

CMS proposes that Exchanges can make the 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.

Termination Effective Dates

Currently, Exchange enrollee-initiated terminations are subject to certain definitions. For example, "reasonable notice" is defined as at least 14 days before the requested termination effective date. Under current regulations, there are three possible effective dates for enrollee-initiated terminations:

1) the termination date specified by the enrollee, if the enrollee provides reasonable notice;
2) 14 days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice; or

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3) a date on or after the date on which the termination is requested by the enrollee, if the enrollee's QHP issuer agrees to effectuate termination in fewer than 14 days, and the enrollee requests an earlier termination effective date.

Further, the QHP termination effective date for enrollees newly eligible for Medicaid, CHIP, or the basic health program is the day before the individual is determined eligible for Medicaid, CHIP, or the basic health program.

CMS proposes to allow Exchange enrollees to request same-day or prospective coverage termination dates.

Rate Review

CMS proposes several changes related to rate review, including:

- Eliminating the requirement that proposed and final rate increases must be posted at a uniform time, instead allowing states with Effective Rate Review Programs to publish proposed and final rate increases on a rolling basis.
- Exempting student health insurance coverage from the federal rate review process.
- Allowing states with Effective Rate Review Programs to have different submission deadlines for issuers that only offer non-QHPs.
- Reducing the advanced notification that states must give CMS about the posting of rate increases from 30 days to 5 business days.
- Increasing the default threshold for rate increases subject to review to 15 percent from 10 percent.

Medical Loss Ratio (MLR)

CMS proposes to allow issuers the option to either continue tracking and reporting actual Quality Improvement Activity (QIA) expenses or report a standardized amount equal to 0.8 percent of the issuer's earned premium for the year without having to separately track such expenses.

CMS also proposes to reduce the burden on states associated with requesting adjustments to the 80 percent MLR standard in the individual market by simplifying the application process and by making it easier for the Secretary to grant state requests.

Minimum Essential Coverage (MEC) Designation for CHIP Buy-In Program

A CHIP program is a type of government-sponsored coverage that provides low-cost health coverage to children in low-income families that do not otherwise have health coverage. States may be eligible to receive federal funds to initiate and expand such programs.

A CHIP buy-in program, a "full pay" option where a covered family pays the full premium typically without any federal or state assistance, often provides similar or identical benefits as the state CHIP program for children in families that do not financially qualify for the state's CHIP program. CHIP buy-in programs are not authorized or funded under the law that authorizes CHIP, so CHIP buy-in programs are not government-sponsored minimum essential coverage.

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Per the HHS Secretary's authority (in consultation with the Secretary of the Treasury) to recognize certain programs as minimum essential coverage, CMS proposes to categorically designate CHIP buy-in programs that provide identical coverage to a state's CHIP program as MEC without going through an application process.

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